Provider Inquiry Form

INSTRUCTIONS

Delta Dental requires providers submit a claim adjustment (resubmission) by selecting that option on this form to adjust claims for clerical corrections, or to provide additional information to support the original claim submitted. A claim adjustment review can be completed by Delta Dental in 30 days or less.

Provider disputes will only be processed as a dispute if the provider has first attempted to resubmit the claim for adjustment or additional review prior to the dispute being filed.

INQUIRY TYPE: (check one)

☐ Claim Adjustment* - completed in 30 days or less*

☐ Provider Dispute - submit after Claim Adjustment denial - written response within 45 working days.

* Multiple like claims can be attached.

Disputes must be written and must clearly describe the basis of the dispute. If you wish to file a dispute with Delta Dental, please complete the form below, include all supporting documentation and clearly identify why you are disputing Delta Dental's action (or inaction). Disputes not submitted on this form or lacking necessary information to resolve the dispute can be returned to you with a request for more information. Delta Dental will acknowledge receipt of your dispute within 2 working days if received via Provider Portal or 15 working days if received by mail, and send a written resolution to your dispute within 45 working days. Contracted/participating providers who are not satisfied with the resolution of a dispute should refer to their provider agreement for further options.

Provider Name:	**Provider Tax ID #:** _____ **Provider License:** _____
Provider Address:	

The mailing address for resubmissions and provider disputes is P.O. Box 997330, Sacramento, CA 95899-7330. We protect the privacy of sensitive information. For more information on Delta's protection of sensitive information, see our Privacy Statement.

SPECIALTY

☐ General Dentist ☐ Endodontist ☐ Oral Surgeon ☐ Orthodontist

☐ Pediatric Dentist ☐ Periodontist ☐ Prosthodontist ☐ Other _____

(please specify type of "other")

Patient Name:	Patient Date of Birth:	
Enrollee Name:	ID Number: Primary _____ Secondary _____	Claim Number:
Date(s) of Service:		
Description of Dispute:		

Contact Name (Please Print) | Title | Phone Number

Provider Signature | Date | Fax Number