

PROVIDER INQUIRY FORM

INSTRUCTIONS

Delta Dental requires providers use a "resubmission" request by selecting that option on this form to resubmit claims for clerical corrections, or to provide additional information to support the original claim submitted. A claim review for resubmission 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 correction or additional review prior to the dispute being filed. Provider disputes receive a written response within 45 days.

INQUIRY TYPE: (check one)

- Claim Resubmission - completed in 30 days or less
- Provider Dispute - resubmission option required, written response within 45 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 providers with Delta Dental of California who are not satisfied with the resolution of a dispute may initiate arbitration with Delta Dental under the Commercial Rules of the American Arbitration Association.

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 _____	Claim Number:
	Secondary _____	
Date(s) of Service:		
Description of Dispute:		

_____	_____	_____
Contact Name (Please Print)	Title	Phone Number
_____	_____	_____
Provider Signature	Date	Fax Number