DELTA DENTAL®

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/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 _____