DELTA DENTAL

Mail Your Completed Form To:
Delta Dental Insurance Company
Washington DC HSCSN Medicaid Program
P.O. Box 1830
Alpharetta, GA 30023-1830

# Provider Dispute Form

Disputes must be written and clearly describe the basis on which you are disputing Delta Dental's action (or inaction.) Complete this form and include all supporting documentation. For assistance Medicaid providers can call 1-888-258-8023. Disputes lacking necessary information will be returned to you.

Delta encourages you to file a dispute only in situations where all required documentation has been previously reviewed. Do not file this form to correct claims that lacked complete/correct information, for issues older than 365 days from Delta Dental's last action/inaction, or for simple clerical errors that can be resolved by the Provider Customer Service.

## Requestor/Provider Information:

| | | |
|---|---|---|
| **Provider Name:** | **Provider TIN/License #:** | |
| **Address:** | | |
| **City:** | **State:** | **ZIP:** |
| **Contact Name:** | | |
| **Phone:** | **Fax:** | **Email:** |

## Patient/Claim Information:

| | |
|---|---|
| **Patient Name:** | **Member Name:** |
| **Member ID#:** | **Patient Date of Birth:** |
| **Claim Number:** | **Date(s) of Service:** |
| **Billed Amount:** | **Disputed Amount:** |

## Dispute Type:

| | | |
|---|---|---|
| ☐ **Consultant Reevaluation** | ☐ **Miscommunication** | ☐ **Other** |
| ☐ **Recovery Request** | ☐ **Timely Filing Denial** | ☐ **Benefits/Eligibility** |
| ☐ **Claim Denial** | ☐ **Medical Necessity Denial** | ☐ **Processing Policy** |

## Description of Dispute:


#1358200 (08/26)