DELTA DENTAL®

PROVIDER DISPUTE FORM

INSTRUCTIONS

California law requires that Delta Dental of California make available to all providers the ability to file disputes. Disputes must be written and must clearly describe the basis of the dispute. If you wish to file a dispute with Delta, please complete the form below, include all supporting documentation and clearly identify why you are disputing Delta's action (or inaction). Disputes not submitted on this form or lacking necessary information to resolve the dispute will be returned to you with a request for more information.

Delta encourages you to file a dispute only in situations where Delta has reviewed all required supporting documentation. Do not file this form if a claim was not processed because it lacked supporting documentation, if the dispute concerns an issue that is older than 410 days from Delta's last action/inaction, or if there has been a simple clerical error that could easily be resolved by Delta's Customer Service staff.

Delta will acknowledge receipt of your dispute within 15 working days 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 under the Commercial Rules of the American Arbitration Association.

The mailing address for filing provider disputes is P.O. Box 997330, Sacramento, CA 95899-7330. Please do not submit disputes via e-mail as the protections may not meet federal healthcare privacy standards and this method does not adequately allow for supporting documentation.

Please fill out this form as completely as possible. Fields with an asterisk (*) are required. This information will help us to resolve your dispute. We protect the privacy of sensitive information. For more information on Delta's protection of sensitive information, see our Privacy Statement.

***PROVIDER NAME:**	***PROVIDER TAX ID #:** ***PROVIDER LICENSE:**
***PROVIDER ADDRESS:**	

PRACTICE: ☐ G.P. ☐ Endodontist ☐ Oral Surgeon ☐ Orthodontist ☐ Pediatric Dentist
☐ Periodontist ☐ Prosthodontist ☐ Other _____
(please specify type of "other")

DISPUTE TYPE: (check one)
☐ Claim
☐ Reimbursement/Overpayment
☐ Processing Policy
☐ Billing Determination
☐ Other

* CLAIM INFORMATION ☐ Single ☐ Multiple "LIKE" Claims (attach copies)

*Patient Name:	*Patient Date of Birth:	
*Subscriber 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