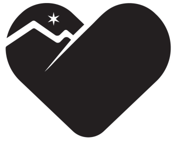

DENVER HEALTH MEDICAL PLAN INC.™

Date: ______________________________

Provider Name: ______________________________

Vendor Name: ______________________________

Vendor Tax Identification Number: ______________________________

DHMP (Denver Health Medical Plan) Claim Number: ______________________________

Date of Service(s): ______________________________

Subscriber or Member Name: ______________________________

Subscriber or Member ID Number: ______________________________

Patient Name: ______________________________

Patient Date of Birth: ______________________________

Dollar Amount in dispute, if applicable: ______________________________

Provider position statement explaining the nature of the dispute (please attach copy of the DHMP remittance advice):

______________________________

______________________________

______________________________

______________________________

Supporting Documentation: **please attach**
Proof of timely filing: **please attach**
Proof of authorization or authorization number, if the service in question requires authorization:

______________________________

Contact Name: ______________________________

Address ______________________________

______________________________

______________________________

Telephone Number: ______________________ Fax Number: ______________________________

E-Mail Address if applicable: ______________________________

**Please mail back to:**

**Denver Health Medical Plan, Inc.**
**Grievances and Appeals-Provider Dispute Resolutions**
**P.O. Box 24992**
**Seattle, WA 98124-0992**