Provider Request for Payment Reconsideration

DENVER HEALTH MEDICAL PLAN INC.™

The Provider Reconsideration Process is available to all providers to resolve claim payment issues. Reconsiderations must be submitted on this form within 60 business days from the Remittance Advice (RA) date. Please note, reconsiderations regarding prior authorization denials must include an explanation of the extenuating circumstances that prevented the provider from following standard utilization management rules for obtaining an authorization prior to rendering services.

Date: _____

1. Claim Information

DHMP (Denver Health Medical Plan) Claim Number(s):_____

_____

Date of Service(s): _____

Provider Name: _____

Provider TIN: _____

Member Name:_____

Member Date of Birth: _____

Subscriber Name:_____

Dollar Amount in dispute, if applicable:_____

2. Reason for reconsideration (please attach copy of the DHMP remittance advice and circle impacted claims):

_____

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_____

_____

_____

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

_____

3. Billing Provider Information

Contact Name: _____

Address

_____

_____

_____

Telephone Number:_____ Fax Number: _____

E-Mail Address if applicable: _____

Please mail to:

Denver Health Medical Plan, Inc.
Provider Reconsiderations
P.O. Box 24992
Seattle, WA 98124-0992