



PROVIDER REQUEST FOR PAYMENT RECONSIDERATION

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

_____ Subscriber Name Member Name Member ID #

_____ Member Date of Birth Dollar Amount in Dispute (if applicable)

2. REASON FOR DISPUTE (please attach copy of the DHMP remittance advice and circle impacted claims):

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

_____ Email Address, if applicable

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