DENVER HEALTH MEDICAL PLAN INC.™

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
Attn: Provider Reconsiderations
P.O. Box 6300
Columbia, MD 21045