

PROVIDER INQUIRY FORM

INSTRUCTIONS

Dentegra requires providers submit a claim adjustment (resubmission) by selecting that option on this form to adjust claims for clerical corrections, or to provide additional information to support the original claim submitted. A claim adjustment review can be completed by Dentegra in 30 days or less.

Provider disputes will only be processed as a dispute if the provider has first attempted to resubmit the claim for adjustment or additional review prior to the dispute being filed.

INQUIRY TYPE: (check one)

- Claim Adjustment* - completed in 30 days or less*
 - Provider Dispute - submit after Claim Adjustment denial - written response within 45 working days.
- * Multiple like claims can be attached.

Disputes must be written and must clearly describe the basis of the dispute. If you wish to file a dispute with Dentegra, please complete the form below, include all supporting documentation and clearly identify why you are disputing Dentegra's action (or inaction). Disputes not submitted on this form or lacking necessary information to resolve the dispute can be returned to you with a request for more information. Dentegra will acknowledge receipt of your dispute within 2 working days if received via Provider Portal or 15 working days if received by mail, and send a written resolution to your dispute within 45 working days. Contracted/participating providers with Dentegra who are not satisfied with the resolution of a dispute should refer to their provider agreement for further options.

Provider Name:	Provider Tax ID #: _____
	Provider License: _____
Provider Address:	

The mailing address for resubmissions and provider disputes is P.O. Box 1850, Alpharetta, GA, 30023-1850.
 We protect the privacy of sensitive information. For more information on Dentegra's protection of sensitive information, see our Privacy Statement.

SPECIALTY

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> General Dentist | <input type="checkbox"/> Endodontist | <input type="checkbox"/> Oral Surgeon | <input type="checkbox"/> Orthodontist |
| <input type="checkbox"/> Pediatric Dentist | <input type="checkbox"/> Periodontist | <input type="checkbox"/> Prosthodontist | <input type="checkbox"/> Other _____
(please specify type of "other") |

Patient Name:	Patient Date of Birth:	
Enrollee Name:	ID Number: Primary _____	Claim Number:
	Secondary _____	
Date(s) of Service:		
Description of Dispute:		

Contact Name (Please Print)	Title	Phone Number
Provider Signature	Date	Fax Number