Dell Children's Health Plan
PO Box 37502,
Oak Park MI 48237-0502

Provider Payment Dispute and Claim Correspondence Submission Form

Payment dispute (check the appropriate box):

☐ Reconsideration Dispute ☐ Claim Appeal ☐ Overpayment

The payment dispute process consists of two consecutive options: reconsideration and claim payment appeal.

- **Reconsideration**: For the first time disputing the payment or unsure , choose reconsideration.
- **Payment/Denial Appeal**: If a reconsideration has previously been completed, choose a claim payment appeal.
- **Overpayment Dispute:** If you are disputing an overpayment request, please select overpayment dispute.

Member First/Last Name:	
Member DOB:	
Member ID/Medicaid ID:	
Provider First/Last Name:	
Provider NPI:	
☐ Participating Provider	☐ Non-Participating Provider
Provider Contact First/Last Name:	
Provider Contact Phone:	
Provider Address:	

City:	State:	Zip:
Phone:		
ICN/Claim Number:		
Billed Amount: $	Amount Received: $	
Start Date of Service:	End of Service:	
Authorization Number:		

To ensure timely and accurate processing of your request, please explain the reason for your dispute. If you have additional claim correspondence you want to include, please complete the next section.

Clearly and completely indicate the dispute reason(s). You may attach an additional sheet if necessary or if you have more than one claim dispute. **Please include any appropriate supporting documentation.**

Claim correspondence (check the appropriate box below):

Claim correspondence is defined as additional requested information necessary in order for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

- Itemized bill
- Medical records (in response to a claim denial or request from DCHP)
- Corrected claim
- Other insurance/third-party liability
- Other correspondence information
- Multiple claims

Clearly and completely indicate the reason(s) for your correspondence. You may attach an additional sheet if necessary.

Please submit this form through the DCHP Provider Portal or mail or fax this form and supporting documentation to:

Payment Dispute Unit
Dell Children's Health Plan
PO Box 37502,
Oak Park MI 48237-0502
Fax Number: 1-586-693-4820