



Provider Claim Resubmission /Reconsideration Form

Mail to: Delaware Physicians Care, Incorporated **From: (contact)**
Claims Department
Attention: Claims Resubmission/Reconsideration
P.O. Box 61145
Phoenix, AZ 85082-1145 **Phone:**

_____ **Corrected Claim** _____ **Reconsideration**

Required Information

Member Name _____ Member ID # _____

Date(s) of Service: _____ Remittance Advice Date: _____

Amount Billed: _____ Amount Paid: _____

Claim Number (s) _____

Providers have twelve (12) months from the date of service to correct and resubmit claims if the initial submission was within the one hundred twenty (120) day time period for timely filing. For timely filing reconsiderations, refer to DPCI's criteria to initiate a review to override timely filing.

Please use the space below to supply any other necessary information, along with your attachments, to enable a thorough reconsideration.

Signature of Sender _____ Date _____

**See "DPCI Remittance Advice" instructions prior to submitting a formal appeal.
Please allow 30 days for a response.**