Delta Dental Medicaid™ and Delta Dental Medicare Advantage™

Claim adjustment and NEA attachment request form

This form is to be used for the following Delta Dental government program groups ONLY.

- Medicaid (HMP, HKD, MI Adult Medicaid, Ohio Medicaid)
- Medicare Advantage plans administered by (AR, IN, MI, NC, OH, SD, TN, WI)

DO NOT use this form for commercial or individual plans unless there is coordination of benefits (COB) with a Medicaid or Medicare Advantage plan listed above. Adjustment requests for commercial or individual plans without Medicaid or Medicare Advantage COB must continue to be submitted via the current process. Requests submitted for non-government program plans cannot be processed and will not receive a response.

This form and the below email address are only for claim adjustment and NEA attachment requests. Adjustments are changes to information on a fully processed in-for-pay claim. Examples include changes to the provider information, member ID, patient, tooth#, procedure code, submitted amount, etc., as well as updates to COB information. Please allow 7–10 business days for completion. This timeframe may be longer for mass requests. To cancel a claim that has not yet processed, please contact the Medicaid/Medicare Advantage Customer Service Department.

The following are not adjustment requests and cannot be processed or responded to via this form:

- **Reconsideration requests—**submit via US mail unless otherwise indicated on the EOB
- **Non-NEA X-ray or narrative submissions—**submit via US mail unless otherwise indicated on the EOB
- **IR responses (other than COB adjustments)—**submit via US mail unless otherwise indicated on the IR
  For COB, include other carrier, subscriber name, plan type (employer, retiree, individual, etc.) and primary payment or coverage termination date, if applicable.
- **New claims—**submit via DOT, clearinghouse or US mail

Include the first five letters of the patient's first name only. Do not encrypt the email, it will prevent the email from being opened once it is forwarded to the processing staff. By including only the claim number and first 5 letters of the first name, the patient is not identifiable and there is no risk of PHI disclosure. If your office policy requires email encryption, your request must be sent via US Mail.

For requests of more than 15 adjustments, attach multiple forms or an Excel spreadsheet in the same format below.

After completion of this form, click the email link to submit to gpclaimadjust@mydeltadental.com, and include the first claim number in the subject.

Requester name	Office phone #	TIN	Office name	Adj submission date	All claims are Medicaid or Medicare Advantage	Completed by
				12/23/20	☐	Delta Dental Use Only

	First 5 letters of name	Claim number	NEA# if applicable	Details of adjustment request
☐ 1				
☐ 2				
☐ 3				
☐ 4				
☐ 5				
☐ 6				
☐ 7				
☐ 8				
☐ 9				
☐ 10				
☐ 11				
☐ 12				
☐ 13				
☐ 14				
☐ 15				