Dean
HEALTH PLAN

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www.deancare.com

Problem Claim Request Form

If confirmation of receipt for this submission is desired, please indicate how you wish to receive confirmation: ❑ mail ❑ fax

Provider/vendor name _____ Vendor# _____
Provider address _____
_____
Fax number _____

Date sent _____
Who should Dean Health Plan contact with questions regarding the information provided on this form?
_____, at (____) _____, extension _____

Claim Number	Date of Service	Patient Name	Member Number	Amount to Reverse	Description of Problem

Reversals of overpayments will result in an automatic offset against future payments