



Timely Filing Waiver Request

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 _____

DOCUMENTATION REQUIRED*:

- A. Copy of Claim (for processing purposes only) *and*
- B. Electronic Claims Transmission Confirmation Report (ECT) *or*
- C. Paper Claim Receipt Confirmation Report *or*
- D. Rejected Claims Report (previously: Error Recycle Deleted Record Report) *or*
- E. If patient error, proof of timely billing to patient and/or date insurance information was received from patient

➤ **Please note that without one of the items listed in “B-E” your request will not be approved.** ⏪

Patient name _____

Patient’s member # _____

Date(s) of service _____

Claim number(s), if applicable _____

Detailed explanation for untimely filing _____

***Dean Health Plan requires all providers to submit bills according to the limit specified in their contract. To request review of claims submitted past this limit, Dean Health Plan requires this form be completed, in its entirety, and the required supporting documentation be provided.**