DMBA

PROVIDER REVIEW FORM

TYPE OF REVIEW (CHOOSE ONE BELOW)

- ☐ Medical/Dental claim
- ☐ Medical/Dental preauthorization
- ☐ Pharmacy claim
- ☐ Pharmacy preauthorization
- ☐ Corrected bill/coding change

IMPORTANT: Under ERISA (the federal law that governs the patient's health plan), DMBA is required to administer the plan in accordance with its written provisions and terms and cannot make any exceptions.

REVIEW INFORMATION

Contract holder: _____ Patient: _____

DMBA ID number: _____ Authorization number(s) (if applicable): _____

Claim number(s): _____

Provider name: _____ Tax ID number: _____

Facility name: _____ Provider NPI: _____

Provider mailing address: _____

Office contact: _____ Phone number: _____

Tell us below why you are requesting a review of this claim. Attach a separate sheet of paper if necessary: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please send all documentation, including this form, to DMBA, P.O. Box 45530, Salt Lake City, UT 84145. You may also fax it to 801-578-5901.