

From: DMHC Licensing eFiling
Subject: Exhibit W-13 Health Plan Provider Dispute Contacts Form
Date: Tuesday, October 25, 2016 4:12:00 PM
Attachments: W-13 Health Plan Provider Dispute Contacts.docx

Dear Health Plan Representative,

The new form, Exhibit W-13 Health Plan Provider Dispute Contacts, is now available for use under the downloads section in the eFiling system to update the Health Plan Provider Contacts for use by the DMHC's Provider Complaint Unit. The form may be utilized any time to ensure current plan contact information is on file with the Provider Complaint Unit. This form will go into effect on November 1, 2016.

Thank you for your attention to this matter.

HEALTH PLAN PLEASE PROVIDE

Date: Health Plan Name:

License Number:

PROVIDER DISPUTE HEALTH PLAN CONTACT TYPES

The DMHC Help Center maintains two points of provider contact for each health plan:
Only the Internal plan contact information is required.

- Internal
 - This is the primary plan contact that the DMHC Help Center's provider complaint analysts use to notify a health plan that a provider dispute was filed with the department. These notices can be directed to an individual or a unit.
- Quick Resolution:
 - This is the primary plan contact that the DMHC Help Center's provider complaint analysts and providers use while working together in a three-way phone call to resolve a current issue that the providers have with their health plan.

HEALTH PLAN PROVIDER DISPUTE CONTACT 1

Contact Type: Internal Quick Resolution

Contact Status:

First Name: Last Name:

Plan's Unit Name:

Phone Number:

Primary Phone: Extension:

Fax Phone: Extension:

Health Plan Provider Contacts

Type: Phone: Extension:

Type: Phone: Extension:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

E-Mail:

HEALTH PLAN PROVIDER DISPUTE CONTACT 2

Contact Type: Internal Quick Resolution

Contact Status:

First Name: Last Name:

Plan's Unit Name:

Phone Number:

Primary Phone: Extension:

Fax Phone: Extension:

Type: Phone: Extension:

Type: Phone: Extension:

Address Line 1:

Address Line 2:

City:

State:

Health Plan Provider Contacts

Zip Code:

E-Mail:

ADDITIONAL PROVIDER DISPUTE CONTACT INFORMATION

Please add additional provider dispute contacts required for this plan in the space below.

FOR DMHC USE ONLY

e-Filing Number: