

Third Party Payer Complaint Form

Let CDA know what problems you are experiencing with third-party payers with CDA's Third-Party Payer Complaint form. This form gives dentists and dental staff the opportunity to provide CDA with basic information regarding payer issues and complaints. The information received will be used help CDA identify carrier trends and problems.

Date: _____ Component: _____

Name of Caller: _____

Title: Dentist Office Staff Consumer/Patient Other _____

Name of Third Party Payer (Plan): _____

Is the dentist contracted with plan in question?: YES NO

Complaint Category/Subject (Check all that apply):

- | | |
|---|--------------------------|
| Coordination of Benefits (between primary and secondary plan) | <input type="checkbox"/> |
| EOB Language | <input type="checkbox"/> |
| Downcoding/Bundling of Procedures | <input type="checkbox"/> |
| Delayed Payment | <input type="checkbox"/> |
| Denial of Claim or Pre-authorization | <input type="checkbox"/> |
| Denial of Claim after Pre-authorization | <input type="checkbox"/> |
| Lost claims, x-rays or other documentation by carrier | <input type="checkbox"/> |
| Patient Billing Dispute | <input type="checkbox"/> |
| Fees/Maximum Allowances/UCR | <input type="checkbox"/> |
| Refund Demand | <input type="checkbox"/> |
| Other | <input type="checkbox"/> |

Is there any available supporting documentation (e.g., EOB, claim form, etc)?

YES NO

If yes, please submit with complaint form (**Remember to remove any personally identifiable patient information before submitting**)

Please give a brief description of the problem (use back of form if needed):

Would you like someone from CDA to contact you on this issue? YES NO

If yes, please include contact information:

Please return completed form to:

CDA, Attn: Member Programs/Third Party Payer Dept., P.O. Box 13749 Sacramento, CA 95853

Or fax to: 916.498.6177

