

Timely Filing Waiver Request

Use this form to request consideration of a waiver for timely filing.

We can send you confirmation that we received this request. Pick your preferred delivery method:

Mail Fax I don't want confirmation

Provider Information

Provider/Vendor Name:

Vendor Number:

Provider Address:

Fax Number:

()

Date Sent:

Who should we contact with questions regarding this form?

Name:

Phone Number:

()

Extension:

Requests must include documentation to support the reason why timely filing was beyond your control.

Submit a copy of your claim with this request, along with one of the following:

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

Requests without one of the items listed in "A-D" will be denied.

Patient Information

Patient Name:

Patient's Member ID:

Date(s) of Service:

Claim Number(s) (if Applicable):

Detailed explanation for untimely filing:

We require all care providers to submit bills according to the limit specified in their contract. To request review of claims submitted past this limit, we require this form be completed, in its entirety, and the required supporting documentation be provided.

Mail the completed form and required documentation to:

Dean Health Plan by Medica
PO Box 211404
Eagan, MN 55121