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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 Contracts.docx](#)

Dear Health Plan Reviewer:

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: Click here to enter text.

Health Plan Name: Click here to enter text.

License Number: Click here to enter text.

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: Choose an item.

First Name: Click here to enter text. **Last Name:** Click here to enter text.

Plan's Unit Name: Click here to enter text.

Phone Number:

Primary Phone: Click here to enter text. **Extension:** Click here to enter text.

Fax Phone: Click here to enter text. **Extension:** Click here to enter text.

Health Plan Provider Contacts

Type: Choose an item. **Phone:** Click here to enter text. **Extension:** Click here to enter text.

Type: Choose an item. **Phone:** Click here to enter text. **Extension:** Click here to enter text.

Address Line 1: Click here to enter text.

Address Line 2: Click here to enter text.

City: Click here to enter text.

State: Click here to enter text.

Zip Code: Click here to enter text.

E-Mail: Click here to enter text.

HEALTH PLAN PROVIDER DISPUTE CONTACT 2

Contact Type: Internal Quick Resolution

Contact Status: Choose an item.

First Name: Click here to enter text. **Last Name:** Click here to enter text.

Plan's Unit Name: Click here to enter text.

Phone Number:

Primary Phone: Click here to enter text. **Extension:** Click here to enter text.

Fax Phone: Click here to enter text. **Extension:** Click here to enter text.

Type: Choose an item. **Phone:** Click here to enter text. **Extension:** Click here to enter text.

Type: Choose an item. **Phone:** Click here to enter text. **Extension:** Click here to enter text.

Address Line 1: Click here to enter text.

Address Line 2: Click here to enter text.

City: Click here to enter text.

State: Click here to enter text.

Health Plan Provider Contacts

Zip Code: [Click here to enter text.](#)

E-Mail: [Click here to enter text.](#)

ADDITIONAL PROVIDER DISPUTE CONTACT INFORMATION

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

[Click here to enter text.](#)

FOR DMHC USE ONLY

e-filing Number: [Click here to enter text.](#)