Delta Dental Group Plans

Claim adjustment request form (non-Medicaid/Medicare)

This form is to be used for the following Delta Dental Group plans ONLY.

- Groups - MI, IN, OH, NC

Reset Form

DO NOT use this form for Medicaid, Medicare Advantage or individual plans.

This form and the below email address are only for claim adjustment requests. Adjustments are changes to information on a fully processed in-for-pay claim. Examples include changes to the provider information, member ID, patient, tooth#, procedure code, submitted amount, etc., as well as updates to COB information. Please allow 7–10 business days for completion. This timeframe may be longer for mass requests. To cancel a claim that has not yet processed, please contact commercial customer service at 1 (800) 524-0149.

The following cannot be processed via this form:

- **Reconsideration requests—**submit via US mail unless otherwise indicated on the EOB.
- **NEA X-ray or narrative submissions—**submit vis US Mail or through the National Electronic Attachment website.
- **IR responses (other than COB adjustments)—**submit via US mail unless otherwise indicated on the IR. For COB, include other carrier, subscriber name, plan type (employer, retiree, individual, etc.) and primary payment or coverage termination date, if applicable.
- **New claims—**submit via Dental Office Toolkit, clearinghouse or US mail.
- **Orthodontic claim adjustments**

Include the first five letters of the patient's first name only. Do not encrypt the email, it will prevent the email from being opened once it is forwarded to the processing staff. By including only the claim number and first 5 letters of the first name, the patient is not identifiable and there is no risk of PHI disclosure. If your office policy requires email encryption, your request must be sent via US Mail.

For requests of more than 15 adjustments, attach multiple forms or an Excel spreadsheet in the same format below.

After completion of this form, click the email link to submit to provideradjustments@deltadentalmi.com, and include the first claim number in the subject.

Requester name	Office phone #	TIN	Office name	Adj submission date	All claims are for Group Plans MI, IN, OH, NC	Completed by
				06/10/25	☐	Delta Dental Use Only

	First 5 letters of patient's name	Claim number	Details of adjustment request
☐ 1			
☐ 2			
☐ 3			
☐ 4			
☐ 5			
☐ 6			
☐ 7			
☐ 8			
☐ 9			
☐ 10			
☐ 11			
☐ 12			
☐ 13			
☐ 14			
☐ 15			