



Regulation 1316 – Form A
Petition for Non-Network Providers of Emergency Care Services Health Care Reimbursement for
Emergency Care Arbitration

Arbitration Case # _____
(Office use only)

Claimant Name			
Claimant Practice Group			
Claimant Address			
Work Phone #			
Name of insurance company against which you are making a claim			
Insurance company address			
Insurance company phone #			
Name of Policyholder			
Policyholder Address			
Policy #			
Was the policyholder: _____ Patient _____ Spouse _____ Parent or guardian _____ Power of attorney _____ Other			
Date of determination of denial of claim			
Amount of your claim	\$ _____		
Dates of Service	From:	_____	To: _____
Briefly describe the basis for your claim. Be sure to include the individual CPT Codes in dispute and attach the notification or explanation of provider payment (EPP) that you received from the insurance company (if needed, attach separate sheet).			
<p>Prior to the hearing, it is necessary that you submit the appropriate documents to support your Petition to the Delaware Department of Insurance <u>and</u> to the opposing party.</p> <p>Parties may present witnesses on their behalf at the hearing, provided that due notice is given. Please list the name, address, and telephone number of all witnesses you expect to appear on your behalf on a separate sheet and attach it to this form.</p> <p>If a settlement has been offered to you, how much was it? \$ _____</p> <p>Who will represent you at the hearing? _____ Self _____ Attorney If an attorney will represent you, please provide the following: Name: _____ Address: _____ _____ Phone #: _____</p> <p>Under Delaware law, any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement or claim containing false, incomplete, or misleading information is guilty of a felony.</p>			
Your Signature _____	Date _____		
<p>Note: In addition to submitting this form to the Department of Insurance, you must also send a copy of this Petition to the insurance company by certified mail, return receipt requested. Use Form C to provide confirmation to the Department that a copy of this Petition was sent to the insurance company. (Forms are available at www.delawareinsurance.gov.)</p>			
<p>Filing Fee: There is a non-refundable filing fee of \$75 for each claim. Please enclose a check made payable to the Delaware Department of Insurance.</p>			
For the insurance company recipient: Within 20 days of receiving this Petition, you must return a Form B Response to Petition and (1) copy to:	Arbitration Secretary Delaware Department of Insurance 1351 West North St., Suite 101 Dover, DE 19904		