****

**Regulation 1319 – Form B**

**Response to Petition for Primary Care and Chronic Care Management Services Reimbursement Arbitration**

Arbitration Case # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Office use only*)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Respondent Company Name |  | | | | |
| Respondent Address |  | | | | |
|  |  | | | | |
| Respondent Phone # |  | | | | |
| Claimant Name |  | | | | |
| Claimant Practice Group |  | | | | |
| Claimant Address |  | | | | |
| Provider Phone # |  | | | | |
| Name of Policyholder |  | | | | |
| Policyholder Address |  | | | | |
| **Is the plan an SB 227-qualifying plan? (check one) \_\_\_\_ yes, it’s a qualifying individual plan[[1]](#footnote-1), \_\_ yes, it’s a qualifying group plan,[[2]](#footnote-2) \_\_\_ no or I don’t know.** | | | | | |
| Date of determination of claim | |  | | | |
| Dates of Service | | From: |  | To: |  |
| Amount of claim paid by Respondent | | $ | | | |
| Briefly describe the basis for your response/objection to the Petition indicating each CPT Code in dispute and attach the notification or explanation that you sent to the claimant (attach additional sheets as necessary). | |  | | | |
| **Prior to the hearing, it is necessary that you submit the appropriate documents to support your Response to Petition to the Delaware Department of Insurance and to the Claimant.**  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.  If you have made a settlement offer, how much was it? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Who will represent you at the hearing? \_\_\_\_\_\_\_ Self \_\_\_\_\_\_\_\_ Attorney  If an attorney will represent you, please provide the following:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **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.**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Signature of Respondent’s Representative Date | | | | | |
| Return the original and one (1) copy of this Response to Petition to: | | Arbitration Secretary  Delaware Department of Insurance  1351 West North Street, Suite 101  Dover, DE 19904 | | | |
| Note: You must also send a copy of this Response to Petition to the Complainant by first class mail, postage prepaid. Use Form C to provide confirmation to the Department that a copy of this Petition was sent to the Complainant. (Forms are available at [www.insurance.delaware.gov](https://insurance.delaware.gov).) | | | | | |

1. Individual health insurance policy issued under 18 ***Del. C.*** § 3342A [↑](#footnote-ref-1)
2. Group health insurance policy issued under 18 ***Del. C.*** § 3556A [↑](#footnote-ref-2)