

Delaware Department of Insurance
Regulation 1313 – Health Insurance Disputes Between Carriers and Providers
Response to Health Care Reimbursement Arbitration

Arbitration Case # _____
(Office use only)

Respondent Company Name		NAIC#	
Respondent Address			
Respondent Email		Respondent Phone #	

Claimant Name			
Claimant Practice Group			
Claimant Address			
Claimant Email		Claimant Phone#	

Name of Policyholder			
Policyholder Address			
Was the policyholder: ☐ Patient ☐ Spouse ☐ Parent or guardian ☐ Power of attorney ☐ Other			
Date of determination of denial of claim			
Amount of claim admitted by Respondent	\$ _____		
Dates of Service	From: _____	To: _____	
Briefly describe basis for your response/objection and attach the notification or explanation sent to the claimant. (If needed, attach separate sheet)			

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 #: _____	Email: _____
Parties may present witnesses on their behalf. Attach witness list to this form listing each witness's name, email, and phone number.	
Under 11 <i>Del. C.</i> §913, any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.	
Signature of Respondent's Representative _____	Date _____

Note: In addition to submitting this form to the Department of Insurance, you must also send a copy of this Response with supporting documentation to the Complainant or their representative by U.S. First Class postage. Use the Proof of Service form pertaining to Health Care Reimbursement Arbitration to provide confirmation to the Department that a copy of this Response was sent to the Complainant or their representative. Forms are available at: <https://insurance.delaware.gov/services/arbitration/>.

Filing Fee:

There is a non-refundable filing fee of **\$50 for claims of \$1,000 or less** or **\$100 for claims of more than \$1,000**. Please enclose a check or money order payable to the Delaware Department of Insurance.

One (1) copy of the Response filing must be sent to the Claimant or their representative and to the Department. Include appropriate filing fee payment with the Department filing addressed to:

Arbitration Secretary
Delaware Department of Insurance
1351 W. North Street, Suite 101
Dover, DE 19904