

This form is to be used for **medical, vision, and dental claims** where you incurred expenses from a provider who did not bill the plan directly. **Do not use this form for prescription reimbursement.** Please use the Prescription Drug Reimbursement Form (for primary prescription claim submission) or the Secondary Insurance Prescription Drug Claim Form.

See instructions on other side for additional information to complete your claim.

1. Patient / Member <i>NOTE: Complete a separate claim form for each patient/member.</i>					
Prefix and ID number (see ID card)		Group number (see ID card)	Patient name (first, middle, last)		Date of birth (month/day/year)
Address			City	State	ZIP CODE
Home phone number		Work or alternate phone number	Subscriber name (first, middle, last)		
Does the patient have coverage from any other health plan? <input type="checkbox"/> No, skip to section 2 <input type="checkbox"/> Yes, please attach the Explanation of Benefits (EOB) statement from the primary plan with this claim, and complete the following information.					
Name of other health plan			ID number or policy number of other health plan	Phone number of other health plan	
2. Claim Details <i>NOTE: You must submit an itemized bill or your claim will be returned.</i>					
Have the charges been paid in full? <input type="checkbox"/> No <input type="checkbox"/> Yes, please attach proof of payment in full with your itemized bill.					
In what setting were these services performed? <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> Outpatient hospital <input type="checkbox"/> Office/clinic <input type="checkbox"/> Surgery center <input type="checkbox"/> Skilled nursing facility <input type="checkbox"/> Home <input type="checkbox"/> Other:					
3. International Claim <i>NOTE: You must submit an itemized bill or your claim will be returned.</i>					
Is this claim for expenses incurred outside the United States? <input type="checkbox"/> No, skip to section 4 <input type="checkbox"/> Yes, please attach an itemized bill and available medical records, and complete this section.					
Name of provider		Type of provider <input type="checkbox"/> Hospital <input type="checkbox"/> Lab <input type="checkbox"/> Office <input type="checkbox"/> X-ray	Country of service	City of service	Date of service
Diagnosis (describe illness and symptoms requiring treatment)			Charges	Currency used	
4. Accident / Injury					
Is this claim due to an accidental injury? <input type="checkbox"/> No, skip to section 5 <input type="checkbox"/> Yes, complete this section		Date of accident	Where did the accident occur? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Auto <input type="checkbox"/> Other:		
How did the accident happen?					
Description of injury					
5. Signature					
To be accepted, this form must be fully completed (as appropriate to the claim being submitted), signed, and have an itemized bill attached. Mail to: LifeWise Assurance Company, P.O. Box 91059, Seattle, WA 98111-9159					
Patient signature (or legal guardian if patient cannot legally consent to services)			Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Other:		Date (month/day/year)
Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.					

Instructions

A. Complete a claim form. Most providers will bill directly for you and no claim form will be necessary. However, if you do incur expenses from a provider who will not bill the plan directly, you will need to complete a claim form and provide an itemized bill. (See section B for information about itemized bills.)

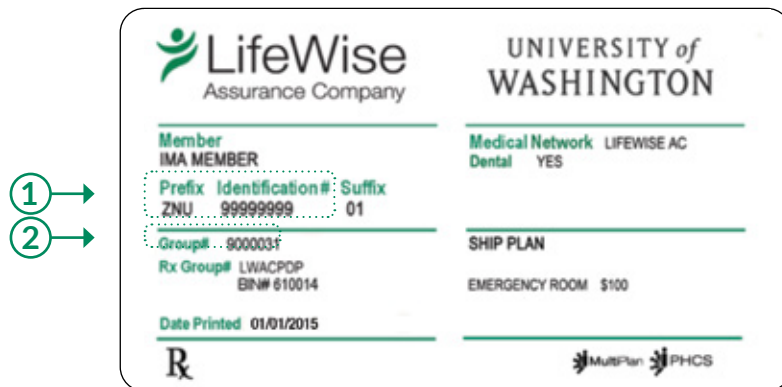
B. Attach the itemized bill. Please do not highlight or modify the itemized bill as this may cause delayed processing of your claim.

The itemized bill must contain all of the following information:

- Name of the member who incurred the expense.
- Name, address, and IRS tax identification number of the provider.
- Diagnosis code (ICD-10). This information must be obtained from your provider.
- Procedure codes (CPT-4, HCPCS, ADA, or UB-04). This information must be obtained from your provider.
- Date of service and itemized charge for each service rendered.

Please note: Your claim will be returned if all of the required information listed above is not included.

C. The front of your member ID card may not match the card pictured below. This sample card is meant to be a guide to help you identify your prefix, identification, and group numbers. These numbers are required to complete your claim form.



1 – Prefix and Identification # help us verify your eligibility, determine your coverage, and process claims.

2 – Group # identifies your plan's benefits.

D. The back of your member ID card provides additional information. To help ensure your claims are paid properly, encourage physicians and other providers to copy the front and back of your card each time you visit. You can research claim and eligibility information online. Visit our self-service website at student.lifewiseac.com. You may also call customer service at the phone number shown on the back of your ID card.

Discrimination is Against the Law

LifeWise Assurance Company (LifeWise) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@LifeWiseHealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

Language Assistance

- ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-971-1491 (TTY: 711).
- 注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-971-1491 (TTY: 711)。
- CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-971-1491 (TTY: 711).
- 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-971-1491 (TTY: 711) 번으로 전화해 주십시오.
- ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-971-1491 (телетайп: 711).
- PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-971-1491 (TTY: 711).
- УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-971-1491 (телетайп: 711).
- ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-971-1491 (TTY: 711)។
- 注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。800-971-1491 (TTY:711) まで、お電話にてご連絡ください。
- ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በገጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-971-1491 (መስማት ለተሳናቸው: 711)።
- XIYYEEFFANNA:** Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-971-1491 (TTY: 711).
- ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-971-1491 (رقم هاتف الصم والبكم: 711).
- ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-971-1491 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
- ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-971-1491 (TTY: 711).
- ໂປດອຸບ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສ່ຽງຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-971-1491 (TTY: 711).
- ATANSYON:** Si w pale Kreyòl Ayisyen, gen sévis èd pou lang ki disponib gratis pou ou. Rele 800-971-1491 (TTY: 711).
- ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-971-1491 (ATS : 711).
- UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-971-1491 (TTY: 711).
- ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-971-1491 (TTY: 711).
- ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-971-1491 (TTY: 711).
- توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-971-1491 (TTY: 711) تماس بگیرید.