LifeWise Assurance Company

Balance Billing Protection Act
Dispute Request Form

Follow the steps below to submit a dispute request to LifeWise Assurance Company.

STOP

For good faith negotiation, LifeWise Assurance Company must receive this completed form within 30 calendar days from the out-of-network provider or facility's receipt of payment notification.

A. Provider information:

Provider of care (doctor's name, hospital, laboratory):		
NPI #:	Tax ID #:	
Provider representative:	Phone #:	Email address:

B. Member information:

First name	Last name:	Date of birth: MM/DD/YY
ID Prefix: (see ID card)	ID #: Suffix:	Group/Policy #:

C. What claims are you disputing?

Note: All claims must be for the provider listed in section A. If disputing for different providers, please use a separate form.

Date of service: MM/DD/YY	Claim #:	Procedure code:	Total charge:
Date of service: MM/DD/YY	Claim #:	Procedure code:	Total charge:

D. Please provide requested payment amount and justification.

E. Fax to:

Fax: 425-953-2947
LifeWise Assurance Company
ATTN: Provider Network Resolution Specialist