Provider Appeal Form – Group Plans

Follow the steps below to submit an appeal request.

LifeWise Health Plan of Washington

A. Provider information:

Who are you appealing for? Please check: ☐ Provider ☐ Member

Provider (e.g.: doctor's name, hospital, laboratory):		
Address:	City/State	ZIP code:
NPI:	Tax ID #:	
Provider contact name:	Phone #:	Fax #:

B. Member information:

First name:	Last name:	Date of birth: MM/DD/YY
ID prefix:(see ID information)	ID #: Suffix:	Group/policy #:

If you're appealing on behalf of your patient regarding a pre-service denial or a request to reduce member cost shares, this is known as a member appeal. The member must sign and complete Section C.

C. Member appeal authorization: Who can appeal on your behalf? Check which one applies and sign below.

☐ Provider listed in Section A

☐ Someone else, please provide information below:

First name:	Last name:	Phone:
Address:	City/State:	ZIP code:

Release of Healthcare Information and Records

By signing this form, I understand and agree to the following:

LifeWise Health Plan of Washington, or any of its affiliates ("the Company"), may disclose my health records to the authorized representative listed on this form.

I understand that the healthcare information may include my benefit, claim, diagnosis, and treatment records including information about the following sensitive healthcare diagnosis and treatment (you may cross off items you prefer not to share).

- Alcohol and/or chemical dependency
- Sexually Transmitted Diseases (including HIV/AIDS)
- Genetic information
- Reproductive health (including abortion)
- Gender-affirming care, gender dysphoria, domestic violence, and behavioral health

You can change your mind and withdraw this release at any time by informing the Company in writing at the address listed on page 2. The Company will make sure the change goes into effect within 5 business days after receiving your withdrawal request and will not be liable for any information released before your change goes into effect. This release is voluntary. We won't condition your health plan enrollment, eligibility for benefits, or claims payment on giving this release. This release lasts 24 months from the signature date or until the appeal process is complete, whichever is earlier.

Member signature: _____ Date_____

Member printed name: _____

D. What are you appealing?

Type of request (if known):

- ☐ Level I appeal
- ☐ Level II appeal

Please select the one that most applies:

- ☐ Pre-service denial (services not yet provided)
- ☐ Claim/service processed

Please provide information below:

Date of service: MM/DD/YY	Claim number:	Total charge:
Utilization management reference #: (listed on denial letter)		

E. Tell us the why you are appealing:

What would you like us to review again? Write in the space below and be sure to attach supporting documents.	**What action do you want us to take?** Write in the space below. If you need more space, please attach a written statement.

F. Send to the appeals department or clinical appeals, depending on the following:

Provider contract related?

- Inclusive procedures/clinical edits
- Allowed amount not applied per provider's contract
- Multiple modifier reimbursements

Send to:

Fax: 425-918-5592

LifeWise Health Plan of Washington
ATTN: Appeals Department
P.O. Box 91102
Seattle, WA 98111-9202

Clinical related?

- Lack of medically necessary criteria
- Issues with prior authorization

Send to:

Fax: 425-918-4133

LifeWise Health Plan of Washington
ATTN: Clinical Appeals
P.O. Box 91102
Seattle, WA 98111-9202