Balance Billing Protection Act Dispute Request Form

Follow the steps below to submit a dispute request to Premera Blue Cross.

PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

STOP

For good faith negotiation, Premera Blue Cross 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:
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D. Please provide requested payment amount and justification.

E. Fax to Premera

Fax: 425-953-2947
Premera Blue Cross
ATTN: Provider Network Resolution Specialist