Balance Billing Protection Act Dispute Request Form

PREMERA HMO
An Independent Licensee of the Blue Cross Blue Shield Association

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

For good faith negotiation, Premera Blue Cross HMO 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 Premera HMO

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