



An **itemized bill** is a form the provider uses that details the services received by the member and the cost of each service. It is not a statement which shows only the balance due. Please do not highlight or modify receipts as this may cause delayed processing of your claim.

**Complete a separate claim form for each provider of service, such as doctor or laboratory.**

**Please do not use for more than one provider or patient.**

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**4. FOR DENTAL CLAIM** (ITEMIZED BILL MUST BE ATTACHED)

**A.** Was the treatment for orthodontic care?  No  Yes

**B.** Did treatment include an artificial device(s) such as dentures, bridge(s), crown(s), etc.?  No  Yes

If "Yes," was the treatment to replace an existing artificial device? \_\_\_\_\_

If "Yes," please explain why the replacement was necessary and give the date (if known) of the last replacement. \_\_\_\_\_

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**5. FOR VISION CLAIM** (ITEMIZED BILL MUST BE ATTACHED)

If lenses were prescribed, what type?  Single  Bifocal  Trifocal  Contact  Other (please specify) \_\_\_\_\_

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**6. FOR ALL OTHER CLAIMS — DOCTOR, CLINIC, LAB, ETC.** (ITEMIZED BILL MUST BE ATTACHED)

What was the condition requiring treatment? (Diagnosis)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check here if routine physical examination

Is the condition work related?  No  Yes

Has the patient or will the patient file a workers' compensation claim?  No  Yes

Is this a second surgical opinion?  No  Yes

Is this a third surgical opinion?  No  Yes

Surgical procedure \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ACCIDENT INFORMATION**

Was the reason for treatment due to an accident?  No  Yes

Where did the accident occur?  
 At work  At home  Auto  Other \_\_\_\_\_

What was the exact date of the accident/injury? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Month / Day / Year)

If auto accident, do you have:

Personal injury protection?  No  Yes

Uninsured or underinsured coverage?  No  Yes

Medical payment coverage?  No  Yes

Name and address of auto insurance company:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you intend to make a claim against a third party?  No  Yes

A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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**X**

Patient's signature (or legal guardian if patient cannot legally consent to services)

\_\_\_\_\_  
Date (Month/Day/Year)

To be accepted, this form must be fully completed (as applicable to the claim being submitted), signed, and have proper bills attached.

Mail to: LifeWise Health Plan of Washington  
P.O. Box 91059  
Seattle, WA 98111-9159