

**Practice Resource Center**  
*Helping Physicians' Practices Achieve Clinical and Business Excellence<sup>SM</sup>*

**INSURANCE CLAIM - ASSISTANCE REQUEST**

Complete this form and the Business Associate Agreement to request the WSMA's assistance in resolving problems with your insurance claims.

Today's date: \_\_\_\_\_ Phone \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Fax \_\_\_\_\_

Practice Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

- Payor:
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Medicare        | <input type="checkbox"/> Traditional        | <input type="checkbox"/> Managed Care                   |
| <input type="checkbox"/> Medicaid        | <input type="checkbox"/> Fee For Service    | <input type="checkbox"/> Managed Care (Healthy Options) |
| <input type="checkbox"/> Industrial      | <input type="checkbox"/> Labor & Industries | <input type="checkbox"/> Self Insured                   |
| <input type="checkbox"/> TRICARE         |   |   |
| <input type="checkbox"/> Private Insurer | _____                                       |   |
| <input type="checkbox"/> Other           | _____                                       |   |

**Brief Description of the Problem:**

CONFIDENTIALITY NOTE: To report a problem with a patient-specific claim, DO NOT include the patient's name on this form. Instead, include relevant identifiers such as the payor's claim number, and service dates. Also, attach copies of any relevant background material: correspondence, payor's Explanation of Benefits. Mail or fax these to the WSMA.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What WSMA action(s) would best assist you in resolving this problem?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Return this form (and any attachments):**

**Via Mail:** Bob Perna, Director, Health Care Economics  
 Washington State Medical Association  
 2033 Sixth Avenue, Suite 1100  
 Seattle, Washington 98121

Phone: 206.441.9762  
 800.552.0612

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