Dear Provider:

Thank you for your interest in becoming a participating provider in the Lifetime Benefit Solutions Network.

Please complete the form below and either fax or mail directly to Lifetime Benefit Solutions at:

Lifetime Benefit Solutions
Attn: Provider Services Department
115 Continuum Drive
Liverpool, NY 13088

Fax#: 315-448-9129

Please send me an application for participation as a provider with the Lifetime Benefit Solutions Network. My practice information is included below.

Name: ____

Address:____

____

Phone: ________________________________Fax:__________________________________

Email: ____

Specialty:____

Hospital affiliation(s):____

____

Office contact:____

Tax identification number:____

NPI#: ____