HIGHMARK Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

HIGHMARK BLUE SHIELD
PO BOX 890062
CAMP HILL PA 17089-0062

MEMBER SUBMITTED HEALTH INSURANCE CLAIM FORM

FILING INSTRUCTIONS

1. Complete **all** items below **including** your signature and date. **All** of the information is essential for prompt and accurate processing of your claim(s). Please do not highlight information or use red ink.
2. Submit the claim and attach an **itemized** statement of services from the healthcare provider to the address provided on the back of your ID card. Cancelled checks, cash register receipts or personal itemizations are not acceptable.
3. The itemized statement **must** include name of patient, date(s) of service, type of services performed, diagnosis and charge(s).
4. You must use a separate claim form for each patient. All expenses for one patient can be submitted with one claim form.

NOTE: YOU SHOULD MAKE A COPY OF YOUR COMPLETED CLAIM FORM AND ITEMIZED BILLS FOR YOUR RECORDS.

PATIENT INFORMATION

PATIENT'S NAME (first name, middle initial, last name)

PATIENT'S ADDRESS

Street

City State Zip Code

PATIENT'S DATE OF BIRTH (month, day, year)

PATIENT'S SEX ❑ MALE ❑ FEMALE

PATIENT'S RELATIONSHIP TO THE POLICYHOLDER

❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER

POLICYHOLDER INFORMATION

NAME OF POLICYHOLDER (first name, middle initial, last name)

IDENTIFICATION NUMBER ON ID CARD (including any letters)

GROUP NUMBER ON ID CARD

ADDRESS OF POLICYHOLDER

Street

City State Zip Code

If patient is covered by another insurance plan, please complete the following:

OTHER INSURANCE COVERAGE INFORMATION (*If you have an Explanation of Benefits, please attach*)

INSURED'S NAME ON OTHER INSURANCE CARD

OTHER INSURANCE COMPANY POLICY NUMBER

OTHER INSURANCE COMPANY'S NAME

Street

City State Zip Code

IF SERVICE WAS A RESULT OF ACCIDENT, CHECK BELOW:

❑ AUTOMOBILE ACCIDENT ❑ WORK-RELATED ACCIDENT

❑ OTHER: _____

DATE OF ACCIDENT (month, day, year)

DISABILITY DATES _____ THRU _____

STUDENT INFORMATION

IS THE PATIENT A FULL-TIME STUDENT OVER 19 YEARS OLD?

❑ YES ❑ NO

DATES OF CURRENT TERM:

_____ TO _____

SCHOOL NAME AND ADDRESS:

EXPECTED DATE OF GRADUATION:

CERTIFICATION

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, Highmark may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient name.

Signature _____ Date _____

REMEMBER TO ATTACH AN ITEMIZED STATEMENT OF SERVICES PERFORMED