



An Independent Licensee of the Blue Cross and Blue Shield Association

WHERE TO MAIL THIS FORM:
CUSTOMER SERVICE CENTRAL
HIGHMARK BLUE SHIELD
P.O. BOX 890035
CAMP HILL, PA 17001-9888

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 PERSON NAMED ON ID CARD
SELF SPOUSE CHILD OTHER

ID CARD INFORMATION

NAME ON ID CARD (first name, middle initial, last name)
IDENTIFICATION NUMBER ON ID CARD (including any letters)
GROUP NUMBER ON ID CARD
ADDRESS OF PERSON LISTED ON ID CARD
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
SCHOOL NAME AND ADDRESS:
DATES OF CURRENT TERM: TO
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