HIGHMARK BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

MEMBER SUBMITTED MAJOR MEDICAL 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. Attached itemized bill must include:
   - Provider's name and address (on the provider's stationary)
   - Patient's full name (no nickname, please)
   - Date of each service/supply/purchase; Type of services/supply/purchase; Charge
   - If prescription drugs, prescription drug name and number
   - For private duty nursing, Nurse's license number and shift worked
   - For ambulance services, From - To and total mileage

   NOTE: Cancelled checks, cash register receipts or personal itemizations are not acceptable as itemized bills
3. You must use a separate claim form for each patient. All expenses for one patient can be submitted with one claim form.
4. Mail completed claim form with all attached itemized bills to:
   HIGHMARK MAJOR MEDICAL, P.O. BOX 890393, CAMP HILL, PA 17089-0393.

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 SUBSCRIBER NAMED ON ID CARD

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

ID Card Information

SUBSCRIBER'S 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

Other Insurance Coverage Information (*If you have an Explanation of Benefits, please attach*)

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

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 _____

Diagnosis or Nature of Illness or Injury

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