ATTACH RECEIPTS HERE

Independence Blue Cross
Highmark Blue Shield

Independent Licensees of the Blue Cross and Blue Shield Association

Please Mail To: **Highmark Blue Shield**
**P.O. Box 890062**
**Camp Hill, PA 17089-0062**

# CLAIM FORM

Please Print or Type *(see instructions on reverse side)*

**1.**

| NAME ON ID CARD *(First, Middle, Last)* | IDENTIFICATION NUMBER *(Include any letters)* | GROUP NUMBER | |
|---|---|---|---|
| PRESENT STREET ADDRESS | CITY | STATE | ZIP CODE |

IF THIS IS A NEW ADDRESS, DO YOU AUTHORIZE US TO CHANGE YOUR PERMANENT RECORD? ☐ YES ☐ NO

SUBSCRIBER'S EMPLOYMENT STATUS
☐ ACTIVE ☐ RETIRED ☐ PERMANENTLY DISABLED

SPOUSE'S EMPLOYMENT STATUS
☐ ACTIVE ☐ RETIRED ☐ PERMANENTLY DISABLED

ONLY CHECK IF YOUR BLUE SHIELD MEDICAL/SURGICAL CONTRACT IS: ☐ PLAN B ☐ PLAN 1800S ☐ PLAN C ☐ PLAN 5000S

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS: MY CONTRACT IS: ☐ SINGLE/NO DEPENDENT ☐ FAMILY

HOUSEHOLD INCOME FOR THE CALENDAR YEAR PRECEDING DATES OF SERVICE WAS:
☐ UNDER $3,999 ☐ $4,000-$5,999 ☐ $6,000-$11,999 ☐ $12,000-$17,999 ☐ $18,000-$23,999 ☐ $24,000-$35,999 ☐ $36,000 AND OVER

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 named. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement or 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.

Subscriber's Signature _____ Date _____ (Area Code) Home Phone ( ) _____ (Area Code) Work Phone ( ) _____

**2.**

| PATIENT'S FULL NAME *(First, Middle, Last)* | PATIENT'S DATE OF BIRTH / / | SEX ☐ MALE ☐ FEMALE | RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ HANDICAPPED DEPENDENT ☐ OTHER _____ |
|---|---|---|---|

**3.** SUMMARY OF RECEIPTS ATTACHED

| PROVIDER'S NAME | PATIENT'S ILLNESS/INJURY | DATE OF SERVICE | DATE CONDITION FIRST TREATED |
|---|---|---|---|
| | | | |

**4.**

DID CONDITION RESULT IN TEMPORARY DISABILITY? ☐ YES ☐ NO
IF YES, PLEASE SPECIFY DATE(S) OF DISABILITY: FROM ___/___/___ THROUGH ___/___/___

WERE EXPENSES DUE TO AN INJURY? ☐ YES ☐ NO IF YES,
GIVE DATE OF INJURY: ___/___/___ GIVE TYPE/PLACE OF INJURY: ☐ WORK ☐ HOME ☐ AUTO ☐ MOTORCYCLE ☐ OTHER_____

GIVE BRIEF DESCRIPTION OF INJURY: _____

HAS CLAIM BEEN OR WILL CLAIM BE FILED UNDER ANY WORKER'S COMPENSATION ACT? ☐ YES ☐ NO
IF YOU WERE INJURED, HAVE YOU CONTACTED A LAWYER? ☐ YES ☐ NO
IF YES, PROVIDE YOUR ATTORNEY'S NAME AND ADDRESS: _____

**5.** MEDICARE:
IF THE PATIENT IS COVERED BY MEDICARE, PROVIDE THE FOLLOWING INFORMATION:
PART A: ☐ YES ☐ NO EFFECTIVE DATE ___/___/___
PART B: ☐ YES ☐ NO EFFECTIVE DATE ___/___/___
HEALTH INSURANCE NUMBER FROM MEDICARE ID CARD

**6.** **OTHER COVERAGE:**
DOES THE PATIENT HAVE ADDITIONAL HEALTH INSURANCE: ☐ YES ☐ NO If yes, please complete the following information:

| POLICYHOLDER'S NAME | BIRTHDATE / / | RELATIONSHIP OF PATIENT TO POLICYHOLDER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER |
|---|---|---|

| INSURANCE CARRIER'S NAME | AGREEMENT/ID NUMBER | EFFECTIVE DATE / / |
|---|---|---|

TYPE(S) OF COVERAGE:
☐ HOSPITALIZATION ☐ MEDICAL/SURGICAL ☐ DENTAL
☐ VISION ☐ DRUG ☐ MAJOR MEDICAL
☐ OTHER *(Specify)*: _____

CONTRACT COVERS:
☐ POLICYHOLDER ONLY ☐ POLICYHOLDER/SPOUSE
☐ POLICYHOLDER/CHILD(REN) ☐ FAMILY