HIGHMARK. BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 3355
Pittsburgh, PA 15230

COMPREHENSIVE MEDICAL CLAIM FORM

TO BE COMPLETED BY EMPLOYEE (MEMBER)

EMPLOYEE INFORMATION:

1. EMPLOYEE'S NAME (LAST) (FIRST) (MIDDLE INITIAL)

2. GROUP NUMBER
0 _ _ _ _ _ - _ _

3. EMPLOYEE'S ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)

4. EMPLOYEE'S IDENTIFICATION NUMBER

5. EMPLOYEE'S PHONE NUMBER
( )
AREA CODE

PATIENT INFORMATION:

6. PATIENT'S NAME (LAST) (FIRST) (MIDDLE INITIAL)

7. PATIENT'S BIRTH DATE
MONTH | DAY | YEAR

8. PATIENT'S SEX
❑ MALE
❑ FEMALE

9. PATIENT'S RELATIONSHIP TO MEMBER
❑ SELF ❑ SPOUSE ❑ CHILD

10. DIAGNOSIS OR NATURE OF ILLNESS

11. WAS AN ACCIDENT INVOLVED? ❑ YES ❑ NO
IF YES WHEN? MONTH | DAY | YEAR
WHERE: ❑ AUTO ❑ WORK ❑ OTHER:
(ENCLOSE A BRIEF DESCRIPTION OF HOW AND WHERE ACCIDENT OCCURRED)

OTHER COVERAGE:

12. IS THE PATIENT COVERED BY ANY OTHER INSURANCE PLAN? ❑ YES ❑ NO

IF YES
NAME OF INSURANCE COMPANY
POLICY NUMBER
ADDRESS OF INSURANCE COMPANY

13. IS THE PATIENT ELIGIBLE FOR MEDICARE? ❑ YES ❑ NO

IF YES
MEDICARE PART A EFFECTIVE DATE MONTH / DAY / YEAR
MEDICARE PART B EFFECTIVE DATE MONTH / DAY / YEAR

14. IS THE PATIENT A FULL-TIME STUDENT OVER 19 YEARS OLD? ❑ YES ❑ NO

IF YES
SCHOOL NAME
DATES OF CURRENT TERM
_____ TO _____
SCHOOL ADDRESS
EXPECTED DATE OF GRADUATION

ASSIGNMENT OF BENEFITS: *(Outside Pennsylvania Only)*

ATTENTION EMPLOYEE:

15. THIS SECTION APPLIES TO OUTSIDE PENNSYLVANIA PROVIDERS ONLY. IF YOU DO NOT WISH TO SIGN, PAYMENT WILL BE SENT DIRECTLY TO YOU.
PLEASE NOTE: A SEPARATE CLAIM FORM IS NEEDED FOR EACH PROVIDER TO WHOM YOU ARE ASSIGNING BENEFITS.
I HEREBY AUTHORIZE PAYMENT TO THE PROVIDER OF SURGICAL AND/OR MEDICAL BENEFITS, IF ANY.

EMPLOYEE SIGNATURE: _____ DATE: _____

NOTE: PLEASE BE SURE THAT THE OUTSIDE PENNSYLVANIA PROVIDER'S FEDERAL TAX CERTIFICATION NUMBER IS PRINTED ON THE ITEMIZED BILL. IF TAX I.D. NUMBER IS NOT PROVIDED, PAYMENT WILL BE SENT TO THE EMPLOYEE/RETIREE.

EMPLOYEE'S SIGNATURE:

16. 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.

X EMPLOYEE'S SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY PHYSICIAN OR OTHER PROVIDER OF SERVICE

PATIENT & EMPLOYEE (MEMBER) INFORMATION

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM.

1. PATIENT'S NAME *(First name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3. MEMBER'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(Street, city, state, zip code)* TELEPHONE NUMBER	5. PATIENT'S SEX MALE ☐ ☐ FEMALE 7. PATIENT'S RELATIONSHIP TO MEMBER SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	6. MEMBER'S I.D. *(Include any letters)* 8. MEMBER'S GROUP NUMBER *(Or Group Name)*
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ☐ ☐ NO B. AN ACCIDENT AUTO ☐ ☐ OTHER	11. MEMBER'S ADDRESS *(Street, city, state, zip code)*

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ ☐ NO	16A. IF AN EMERGENCY CHECK HERE ☐	
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM	THROUGH	DATES OF PARTIAL DISABILITY FROM	THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE *(e.g., public health agency)*		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED	DISCHARGED	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO	CHARGES	

23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE

1
2
3
4

24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. T O S	D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	E. DIAGNOSIS CODE	F. CHARGES	G. DAYS OR UNITS	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER *(I certify that the statements on the reverse apply to this bill and are made a part hereof)* SIGNED DATE	26. HAS FEE BEEN PAID? YES ☐ ☐ NO 30. YOUR SOCIAL SECURITY NO./ TAX I.D. NO.	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO. 34. YOUR TELEPHONE NO.	31. PHYSICIAN'S OR ACCOUNT'S NAME, ADDRESS, ZIP CODE & PROVIDER NO.		

PLACE OF SERVICE CODES

1 — (IH) — Inpatient Hospital
2 — (OH) — Outpatient Hospital
3 — (O) — Doctor's Office
4 — (H) — Patient's Home
5 — — Day Care Facility (PSY)
6 — — Night Care Facility — (PSY)
7 — (NH) — Nursing Home
8 — (SNF) — Skilled Nursing Facility
9 — — Ambulance
0 — (OL) — Other Locations
A — (IL) — Independent Laboratory
B — — Other Medical Surgical Facility
C — (RTC) — Residential Treatment Center
D — (STF) — Specialized Treatment Facility

For Assignment of Benefits to provider, patient must sign at #15 on the front of this claim form.