MEDICARE ADVANTAGE
MEMBER SUBMITTED HEALTH INSURANCE CLAIM FORM

FILING INSTRUCTIONS

THIS FORM IS FOR HIGHMARK MEDICARE ADVANTAGE MEMBERS ONLY. All other Highmark members should use the Member Submitted Health Insurance Form available in the Forms Library.

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. For optimum accuracy please print in capital letters. Shade circles like this ● Not like this ⊗ ⊘ . Or, use text fields to fill out form electronically.
2. Submit the claim form and attach an itemized statement of services from the healthcare provider to the address below:
   Highmark Inc. • P.O. Box 1068 • Pittsburgh, PA 15230-1068
3. The itemized statement of services must include:
   a. Provider's name and address (on the provider's stationery)
   b. Patient's full name
   c. Date, type, and charge of each service, supply, and/or purchase
   d. For private duty nursing: Nurse's license number and shift worked
   e. For ambulance services: From – To and total mileage
4. If the provider required payment in full prior to scheduling an appointment or required payment above and beyond your health insurance plan's cost-sharing amount, also include a copy of the payment receipt. The receipt should reflect the pre-payment amount, any additional amount that may have been charged during the appointment, or any amount that was refunded due to an over estimate of the cost of services paid in advance of an appointment.
5. A separate claim form must be used for each patient. All expenses for one patient can be submitted with one claim form.

NOTE: Canceled checks, cash register receipts, or personal itemization are not acceptable as a receipt or an itemized statement of services.

MAKE A COPY OF YOUR COMPLETED CLAIM FORM AND ALL ATTACHED DOCUMENTATION FOR YOUR RECORDS.

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POLICYHOLDER INFORMATION

NAME ON ID CARD (first name, middle initial, last name)

IDENTIFICATION NUMBER ON ID CARD (including any letters)

GROUP NUMBER ON ID CARD

STREET ADDRESS OF PERSON LISTED ON ID CARD

CITY | STATE | ZIP CODE

PATIENT INFORMATION

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

STREET ADDRESS OF PERSON LISTED ON ID CARD

CITY | STATE | ZIP CODE

PATIENT'S DATE OF BIRTH

MM / DD / YYYY

PATIENT'S SEX

○ MALE ○ FEMALE

PATIENT'S RELATIONSHIP TO THE PERSON NAMED ON ID CARD

○ SELF ○ SPOUSE ○ CHILD ○ OTHER

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

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 ID CARD	OTHER INSURANCE COMPANY'S NAME
OTHER INSURANCE COMPANY POLICY NUMBER	STREET
	CITY STATE ZIPCODE
IF SERVICE WAS A RESULT OF ACCIDENT, SHADE CIRCLE BELOW: ○ AUTOMOBILE ACCIDENT ○ WORK-RELATED ACCIDENT ○ OTHER: _____	DATE OF ACCIDENT ☐☐ / ☐☐ / ☐☐☐☐ MM DD YYYY DISABILITY DATES THRU _____ _____

POLICY HOLDER PHONE NUMBER

Populate the best phone number to contact if Highmark has a question about your claim(s).

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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, the Plan may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices. The signer hereby authorizes any insurer, employer, organization or health care service provider to release to the plan all information relating to past, present and future health care examinations or treatments received by each person covered by this claim/application. 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