

# 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.**



## 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:<br><br><input type="radio"/> AUTOMOBILE ACCIDENT<br><br><input type="radio"/> WORK-RELATED ACCIDENT<br><br><input type="radio"/> OTHER: _____ | DATE OF ACCIDENT<br><table border="1"><tr><td> </td><td> </td><td>/</td><td> </td><td> </td><td>/</td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>MM</td><td>DD</td><td></td><td>YYYY</td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> DISABILITY DATES _____ THRU _____ |   |      | / |   |  | / |  |  |  |  | MM | DD |  | YYYY |  |  |  |  |  |  |
|  |  | / |      |   | / |  |   |  |  |  |  |    |    |  |      |  |  |  |  |  |  |
| MM   | DD   |   | YYYY |   |   |  |   |  |  |  |  |    |    |  |      |  |  |  |  |  |  |

## POLICY HOLDER PHONE NUMBER

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

|  |  |  |   |  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|---|--|--|--|--|
|  |  |  | - |  |  |  | - |  |  |  |  |
|--|--|--|---|--|--|--|---|--|--|--|--|

## 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**