HIGHMARK West Virginia

An Independent Licensee of the Blue Cross and Blue Shield Association

REQUEST FOR PAYMENT

Please complete the following information and submit with receipt/claim.

Only one form is needed per patient each time you submit a claim.

SUBSCRIBER NAME _____

SUBSCRIBER ADDRESS _____

_____

_____

☐ Check if New Address

GROUP NUMBER _____

IDENTIFICATION NUMBER _____

PATIENT'S NAME _____

PATIENT'S BIRTDATE _____

PATIENT'S SEX ☐ M ☐ F

PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD

DOES THE PATIENT HAVE OTHER COVERAGE? ☐ NO ☐ YES

DOES THE PATIENT HAVE MEDICARE COVERAGE? ☐ NO ☐ YES

If yes, submit Medicare Explanation of Benefits with claim.

EFFECTIVE DATES PART A _____ PART B _____

DIAGNOSIS/NATURE OF ILLNESS _____

_____

IF ACCIDENT OR MEDICAL EMERGENCY

DATE OF ONSET/ACCIDENT _____

WORK RELATED ☐ NO ☐ YES

TYPE OF ACCIDENT _____

WAS A THIRD PARTY INVOLVED? ☐ NO ☐ YES

For prescription drugs include on each receipt Rx Number and Name of Drug, Date Rx Filled, and indicate "NEW" or "REFILL."

I CERTIFY THAT THE INFORMATION THIS CLAIM FORM IS CORRECT AND COMPLETE.

SUBSCRIBER SIGNATURE _____

DATE _____

Please mail form and receipts to:

HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA
ATTENTION: CLAIMS DEPARTMENT
PO BOX 7026
WHEELING, WV 26003-0766