HIGHMARK
NORTHEASTERN NEW YORK

PO Box 80
Buffalo, NY 14240-2657

SUBSCRIBER CLAIM FORM

***Mail completed form together with all itemized bills to address shown above.

If claim form is not complete or if any of the itemized bills require further information, such material may be returned to you with additional instructions.

Otherwise all itemized bills will be retained by us and cannot be returned.

ALL QUESTIONS MUST BE ANSWERED. PLEASE PRINT OR TYPE.

Enter names as shown on your Highmark Blue Shield of Northeastern New York (Highmark BSNENY) Identification Card

Subscriber Last Name	First Name	Initial	Highmark BSNENY ID Number	Group Number

Address-Number and Street	Please Check Here if this is a New Address ☐	City	State	ZIP Code

Patient Last Name	First Name	Initial	Date of Birth Month Day Year	Gender	Patient's Relationship to Subscriber
				☐ Male ☐ Female	☐ Self ☐ Spouse ☐ Child

Other Health Insurance Coverage:

Does Patient have additional health insurance coverage through employer or other group health insurance?

☐ Yes ☐ No **If yes**, please complete.

Name of Other Policy Holder	Policy or Identification Number

Policy Effective Date	Type of Coverage	Other Policy Holder's Birth Date
	☐ Single ☐ Family	

Name and Address of Other Insurance Carrier

Medicare Coverage: Is the Patient entitled to Medicare? ☐ Yes ☐ No **If yes**, please complete.

Patient's Medicare Identification Number _____

Medicare Part A (Hospital Insurance) Effective Date _____

Medicare Part B (Medical Insurance) Effective Date _____

Is the Patient employed? ☐ Yes ☐ No Is the Spouse employed? ☐ Yes ☐ No

Were Expenses Due to an Accidental Injury: ☐ Yes ☐ No **If yes**, please complete.

Type of Accident: ☐ Work ☐ Auto ☐ Motorcycle ☐ Other Date of Accident _____

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Itemized Bills for **Service or Supplies must be attached to this form** with the following information indicated:

- Patient's Full Name
- Amount charged for each service or supply
- Date each service or supply was rendered
- Description of each service or supply
- Diagnosis or nature of illness for each service
- Name and address of provider/supplier
- Drug/Medicine bills must contain prescription number and name of prescribing physician
- UPC label (only applicable for an over-the-counter covid test)

NOTE: Cancelled checks or cash register tapes are not acceptable, except for COVID-19 test reimbursement.

In addition: If you have received any payment or rejection notices from Highmark Blue Shield of Northeastern New York or Medicare for those expenses being reported, please attach them.

IMPORTANT NOTICE

"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 shall also be subject to a civil penalty not to exceed Five Thousand Dollars and the stated value of the claim for each such violation."

COVID-19 TEST REIMBURSEMENT NOTICE

By submitting a manual claim for reimbursement of an Over-the-Counter COVID-19 test, the member is attesting that the test was purchased for personal use, not for employment purposes, and will not be reimbursed by another source (including, for example, other insurance, a flexible spending account, a health reimbursement arrangement or a health savings account) or used for resale.

Subscriber's Signature	Date	Home Phone Number:
_____	_____	_____