INSTRUCTIONS FOR COMPLETING THE HIGHMARK OUT-OF-NETWORK MEDICAL CLAIM FORM

Plan Provisions: If You receive Services from a Network Provider, You will not have to file a Claim. If You receive Services from an Out-of-Network Provider, You may be required to file the Claim yourself. To be considered, a Claim must be filed (by You or the Network or Out-of-Network Provider) within one year from the end of the year in which the date of Service occurs.

General Instructions for completing the form

- This form **must** be typed or completed in ink. If you make any changes to your written information, you must initial changes.
- The required claim form is available from GuideStone, the GuideStone website, Highmark member services or the Highmark website.
- Multiple Services for the same family member can be filed with one Claim form. However, a separate Claim form must be completed for each person.
- **Return the completed Claim Form to:** Highmark Blue Cross Blue Shield, the Claims Administrator for the medical component of the Plan, at the following address:

  Highmark Blue Cross Blue Shield
  P. O. Box 1210
  Pittsburgh, PA 15230-1210

- **Attach:** all original itemized bills to the claim form. Itemized bills must include the following information:
  - The name and address of the Service Provider;
  - The patient's full name;
  - The date of service;
  - The amount charged;
  - The diagnosis or nature of Sickness or Injury;
  - For Durable Medical Equipment, the Physician's certification and date of rental or purchase;
  - For Ambulance Service, the total mileage.
- **Copy:** Since originals must be provided to Highmark, please retain a copy of your completed claim form and any accompanying receipts for your records. Once your Claim is received by Highmark, itemized bills cannot be returned.
- Make sure all information is completed properly, and then sign and date the form.
- Failure to include any of the following information may result in the claim not being processed
  - The member's Highmark Group Number (CQM363)
  - Member's Highmark ID number
  - Employee and Patient name, date of birth and address
  - Date and Place of Service
  - Charges
  - Procedure and Diagnosis codes for services rendered
  - Provider Name, Address, and Tax ID number

Follow Up

- Once your Claim is processed, you will receive an Explanation of Benefits (EOB) statement. The statement lists: the Provider's charge, Allowable Charge, Co-payment, Deductible and Co-insurance You are required to pay; total benefits payable; and total amount You owe. You are responsible for paying the Out-of-Network Provider the charges You incurred, including any difference between what You were billed and what the Plan paid.
- **IF you do not receive an Explanation of Benefits (EOB) within 30-days of submission, please call Highmark at 866-472-0924 and speak with a Highmark Representative.**