HIGHMARK.
PO Box 535052
Pittsburgh, PA 15253
(800) 829-1918
www.highmarkblueshield.com

CBS Corporation

Statement of Claim for Retiree/Spouse Eligible for Medicare

INSTRUCTIONS – *Please follow carefully to expedite the processing of your claim.*

Checklist:

- ✓ Use a separate claim form for the retiree and the spouse.
- ✓ Check the box(es) next to the benefit that applies to this claim.
- ✓ Complete the entire claim form.
- ✓ Attach the required documentation noted below.
- ✓ **Enclose all pages of your Medicare Summary Notice.**
- ✓ Mail your claim to the address on this form
- ✓ Keep a copy of all claim information for your records.

The attached claim is for: ☐ **Retiree** ☐ **Spouse**

☐ **In-Hospital Indemnity Plan and Special Programs with Medicare (SPM) Plan** for Inpatient Hospital Confinements
Documentation Required – A copy of all pages of your **Medicare Summary Notice Part A**
☐ **I am enrolled in an HMO.** Check this box if you are attaching a Hospital Confinement and are not eligible for Medicare Part A.

☐ **In-Hospital Indemnity Plan** – Out Patient Surgery
Documentation Required – A statement from the facility on ***letterhead*** showing the ***patient's name, the date of surgery*** and ***the actual surgery that was performed***.

☐ **Special Expense Plan**
Documentation Required – A copy of all pages of your ***Medicare Summary Notice Part B ONLY***. Hospital bills and provider claims **will not** be accepted.

GENERAL INFORMATION

Name of Retiree ***or*** Surviving Spouse, if Retiree is deceased (First, M.I., Last)			Social Security Number
Street Address			
City	State	Zip Code	Telephone Number ( )
Patient's Name (First, M.I., Last)			Patient's Social Security Number
Patient's Date of Birth		Is Patient Eligible for Medicare? ☐ Yes ☐ No	

ACKNOWLEDGEMENT AND AUTHORIZATION

I certify that to the best of my knowledge and belief the above information is true and correct. I hereby authorize any physician, hospital, medical related facility, insurance or reinsurance company to release any information you have about my health to the extent necessary to process this claim. Unless I revoke this authorization in writing at any time prior, this authorization will remain valid for 12 months. A photocopy of this authorization shall be as valid as the original.

_____ _____

Signature of Retiree or Surviving Spouse, or the Retiree's/Surviving Spouse's Authorized Representative — Date

If the person signing above is not a Retiree or Surviving Spouse, please enclose a copy of the Power of Attorney authorizing you to act on behalf of the Retiree or Surviving Spouse, or a copy of the Death Certificate and supporting documentation authorizing you to act on behalf of the estate.

FRAUD STATEMENT (Please read carefully)

Any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

NOTE: If a claim has been denied in whole or in part, please refer to your benefit booklet for additional information. You have the right to request a review of a denied claim. To appeal a claim, file a WRITTEN APPEAL to Highmark Blue Shield within 180 DAYS of the date the application for benefits was denied.

Mail completed claim form to:
Highmark Blue Shield
P.O. Box 535052
Pittsburgh, PA 15253

For more information, call:
1-800-829-1918