

PROVIDER ADDRESS (Street, City, State, Zip Code)  PLEASE REMIT TO:  CASHIER HIGHMARK PO BOX 898820 CAMP HILL, PA 17089-8820				RETURN OF MONIES
PLEASE REMIT TO: CASHIER HIGHMARK PO BOX 898820 CAMP HILL, PA 17089-8820 Make a copy of the completed documer for your records.  REMITTANCE AMOUNT HIGHMARK CHECK NUMBER HIGHMARK AGREEMENT NUMBER CLAIM NUMBER  PATIENT NAME (If an individual patient is affected, record first, middle initial and last name below.)  DATE OF SERVICE  Multiple Patients (If multiple patients are affected, check box and circle names on attached Explanation of Benefits.)  Providing patient information enables us to credit your account in a more efficient and timely manner. Please return a copy of the Explanation of Benefits form with remittance.  REASON FOR INCORRECT PAYMENT: Provider billing error Other insurance liability, please specify: Worker's Compensation Medicare Health Insurance Claim Number) HIGHNARK AGREEMENT NUMBER  CLAIM NUMBER  CLAIM NUMBER  DATE OF SERVICE  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initial and last name below.)  DATE OF SERVICE  Medicale initi	PROVIDER NAME  PROVIDER ADDRESS (Street, City, State, Zip Code)			DATE
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