HIGHMARK®

RETURN OF MONIES

PROVIDER NAME
PROVIDER ADDRESS (Street, City, State, Zip Code)

DATE
PROVIDER NUMBER

PLEASE REMIT TO:

CASHIER
HIGHMARK
PO BOX 898820
CAMP HILL, PA 17089-8820

Make a copy of the completed document 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

❑ Duplicate payment

❑ Processing error

❑ Unable to identify patient

❑ Other insurance liability, please specify:

❑ Worker's Compensation

❑ Motor vehicle related

❑ Medicare _____ (Health Insurance Claim Number)

❑ TEFRA/OBRA

❑ Security 65/65 Special _____ (HIC Number) _____ (ICN Number)

❑ Other Insurer: _____ (Insurer's Name)

PLEASE EXPLAIN: _____