



## PWK (Paperwork) SUPPLEMENTAL CLAIM INFORMATION COVER SHEET

Date: \_\_\_\_\_

Number of pages (including cover sheet): \_\_\_\_\_

**Attention: Document Preparation**  
**Mailing Address: Highmark Blue Cross Blue Shield of Western New York**  
**PO Box 4208**  
**Buffalo, NY 14240**

From (Provider Name): \_\_\_\_\_

Fax Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Office Contact (Sender) Name: \_\_\_\_\_

**Please check one of the following:**

This is a first time submitting electronic claim with the PWK indicator reported on the claim.

**Patient Account Number:** \_\_\_\_\_

This information is for a claim already received by Highmark BCBSWNY.

**Highmark BCBSWNY claim number:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Subscriber ID Number: \_\_\_\_\_

Service Date: \_\_\_\_\_ Total Charges: \_\_\_\_\_

Provider Legacy and/or NPI Number: \_\_\_\_\_

Attachment Control Number: \_\_\_\_\_

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