



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 _____
<input type="checkbox"/> 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:

<input type="checkbox"/> Provider billing error	<input type="checkbox"/> Other insurance liability, please specify:
<input type="checkbox"/> Duplicate payment	<input type="checkbox"/> Worker's Compensation
<input type="checkbox"/> Processing error	<input type="checkbox"/> Medicare _____ (Health Insurance Claim Number)
<input type="checkbox"/> Unable to identify patient	<input type="checkbox"/> Security 65/65 Special _____ (HIC Number) (ICN Number)
	<input type="checkbox"/> Other Insurer: _____ (Insurer's Name)
	<input type="checkbox"/> Motor vehicle related
	<input type="checkbox"/> TEFRA/OBRA

PLEASE EXPLAIN: _____