HIGHMARK
WESTERN NEW YORK

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: _____
