HIGHMARK BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

ASSIGNMENT OF MAJOR MEDICAL CLAIM

DIRECTIONS:

This major medical assignment form is to be filled out completely and filed with each major medical claim form.

If the information has been completely filled out, this major medical assignment will be honored **provided that** the group major medical agreement does **NOT** expressly prohibit assignments.

This form must be signed by both the Patient-Subscriber and the Applicant-Subscriber because the major medical contracts state that the payments are to be made to the Applicant-Subscriber. *(If the Patient-Subscriber is under 18 years of age, the signature of the parent or guardian should be substituted for that of the Patient-Subscriber.)*

Subject to all the terms and conditions of this assignment form and for value received, the Applicant-Subscriber

_____ whose address is
(NAME - PRINT)

_____
(ADDRESS - PRINT)

and the Patient-Subscriber _____
(NAME - PRINT)

hereby assign my/our right to receive payment of a major medical claim under group contract number

_____ , patient-agreement number _____ to:

(NOTE: IF ADDRESS IS A POST OFFICE BOX NUMBER, PLEASE SHOW ACTUAL ADDRESS BELOW)

_____

_____

FACILITY NAME: _____ FACILITY NUMBER

ADDRESS: _____

_____

The Patient-Subscriber and Applicant-Subscriber agree that representatives of Highmark Blue Shield shall have access to any and all of my medical records and claims information in the possession of the assignee in order to verify the receipt of services or supplies as claimed in the attached major medical billing form. Patient-Subscriber and Applicant-Subscriber further acknowledge that any personally identifiable health information (PHI) is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws. In accordance with those laws, Highmark Blue Shield may use and disclose PHI for payment, treatment and health care operations as described in its Notice of Privacy Practices, which is available on their Web site or from their Privacy Department.

Dated this _____ day of _____ 20_____ .

I/We hereby certify that this assignment form is executed freely and willingly and that I/we have a duty to pay the major medical deductible amount and/or coinsurance and that said amount cannot be forgiven.

Patient-Subscriber _____

Applicant-Subscriber _____