HIGHMARK. BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

HOW TO COMPLETE YOUR MEMBER CHANGE FORM

Complete the following fields on the Member Change Form.

1) **Employer Name** - The employer's name.
2) **Telephone Number** - The employer's telephone number.
3) **Association Name** - The Association's name if your group participates in an association.
4) **Group Number** - Unique 8 digit identification number assigned to the group.
5) **Employee** - The employee's last name, first name and middle initial.
6) **Member Identification Number** - The member's Social Security Number.
7) **Effective Date** - The effective date of the change.
8) **Please give a brief description of the changes to be made** - Utilize this field to describe any of the changes below if further clarification is required.

Complete only the sections that apply to changes in member records.

9) Complete the Street Address, City, State, Zip Code, Home Phone,Work Phone, Hire Date, Group No., Report Code, Change to Enrollment Status.
10) **Employee/Contract Holder** - Complete the appropriate fields in this column to indicate changes that apply to the employee/contract holder.
11) **Spouse/Domestic Partner** - Complete the appropriate fields in this column to indicate changes that apply to the spouse of the employee.
12) **Dependent** - Complete the appropriate fields in these columns to indicate changes that apply to the dependent(s) of the employee.
13) **Type of Change**:
    Add - Check this box if adding a new contract holder spouse or dependent to the existing group.
    Termination - Check this box if canceling a member. Indicate the reason for termination.
    Change - Check this box if changing the member's records.
14) **Previous Identification Number** - The Social Security number of the covered individual prior to the change.
15) **Current Identification Number** - The new Social Security number of the covered individual.
16) **Previous Last Name** - The last name of the covered individual prior to the change.
17) **Current Last Name** - The last name of the covered individual.
18) **First Name Middle Initial** - The first name and middle initial of the covered individual.
19) **Sex** - The gender of the covered individual.
20) **Member Status** - The relationship of the spouse/domestic partner or dependent children to the employee. Check the appropriate box.
21) **Birthdate** - The birthdate including Month/Day/Year of the covered individual.
22) **Primary Care Physician Name** - Only Managed Care groups should complete this section.
23) **Primary Care Physician Number** - Only Managed Care groups should complete this section.
24) **Existing Patient?** - Only Managed Care groups should complete this section. Check "Yes" if the covered individual is already a patient of the Primary Care Physician. Check "No" if the covered individual is a new patient.
25) **Marriage Date** - The member's marriage date.
26) **Other Insurance/Medical Insurance** - Complete if you, your spouse/domestic partner or one of your eligible dependents has other health insurance coverage or is eligible for Medicare. Refer to your Medicare card to complete the Medicare Information section.
27) **Signature and Date** - The employee and employer must both sign and date the form.

Once the form is completed, retain the last copy for your records.

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MEMBER CHANGE FORM

Membership Department
P.O. Box 890172
Camp Hill, PA 17089

In order to process this Change Form, the name and Member Identification Number of the Employee/Contract Holder must be completed in the space provided.

Employer Name		**Employer Telephone Number** ( )	**Association Name (if applicable)**	
Group Number	**Employee (Last)**	**(First)**	**(M.I.)**	**Member Identification Number**
Effective Date of Change	**Please give a brief description of the changes to be made.**			

COMPLETE **ONLY** THE SECTIONS THAT APPLY TO **CHANGES** IN MEMBER RECORDS.

Street Address	**City**	**State**	**Zip Code**	**Home Phone** ( )	**Work Phone** ( )
Hire Date	**Group No.**	**Report Code**	**Change Enrollment Status to:** ☐ Single ☐ Parent/Child ☐ Parent/Children ☐ Insured & Spouse/Domestic Partner ☐ Family		

	Employee/Contract Holder	Spouse/Domestic Partner	Dependent	Dependent	Dependent
Type of Change	☐ Add ☐ Change ☐ Terminate (indicate reason for termination) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason for termination) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason for termination) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason for termination) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason for termination) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare
Previous Identification Number					
Current Identification Number					
Previous Last Name	Last	Last	Last	Last	Last
Current Last Name	Last	Last	Last	Last	Last
First Name Middle Initial	First M.I.	First M.I.	First M.I.	First M.I.	First M.I.
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Member Status	(20) Employee	(01) ☐ Spouse (29) ☐ Domestic Partner	(02) ☐ Child (02) ☐ Student (02) ☐ Disabled (05) ☐ Grandchild (07) ☐ Nephew (07) ☐ Niece (17) ☐ Stepchild	(02) ☐ Child (02) ☐ Student (02) ☐ Disabled (05) ☐ Grandchild (07) ☐ Nephew (07) ☐ Niece (17) ☐ Stepchild	(02) ☐ Child (02) ☐ Student (02) ☐ Disabled (05) ☐ Grandchild (07) ☐ Nephew (07) ☐ Niece (17) ☐ Stepchild
Birthdate	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
Primary Care Physician Name					
Primary Care Physician Number					
Existing Patient?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Marriage Date	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year

Please check one if applicable (If additional space is required, attach a separate sheet). If you ☐, your spouse/domestic partner ☐, or dependent(s) ☐, are enrolled in another Program or Medicare, please give the following information:

Name of Insurance Carrier: __________

Group No: __________ Effective Date: __________

Name of Policy Holder: __________

Policy Number: __________

Relationship to Highmark Policy Holder: __________

Policy Holder Date of Birth: __________

Policy Holder Employment Status: ☐ Active ☐ Retired (Date) __________

MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:

Name of Member Last	First	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
			/ /	/ /	/ /
			/ /	/ /	/ /

Why are you eligible for Medicare? ☐ Age ☐ Disability ☐ End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that complements Medicare? ☐ Yes ☐ No

To the best of my knowledge and belief, the information provided on this application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

____
Authorized Employer Signature Date

____
Employee Signature Date

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