PREEXISTING CONDITION FORM

FILING INSTRUCTIONS

Please complete and return this form within fifteen (15) calendar days of receipt as instructed below

1. Please print or type. Please do not highlight or use red ink.
2. To assist in prompt and accurate claim processing, please complete all items below including signature and date.
3. Please return this form via mail to:
   Return Development, P.O. Box 890062, Camp Hill, PA 17089-0062 or fax to 1-866-731-4589
4. For any questions regarding this form, please contact the applicable number below:

   If you are located in Highmark's 29-county Western region, please call: 1-800-547-3627
   If you are located in Highmark's 21-county Central region, please call: 1-866-731-8080

Patient Information	**ID Card Information**
PATIENT'S NAME	SUBSCRIBER'S NAME ON ID CARD
PATIENT'S DOB	IDENTIFICATION NUMBER ON ID CARD
PATIENT'S SEX	EFFECTIVE DATE OF COVERAGE

Provider Information

PROVIDER NAME (first name, middle initial, last name)		
PROVIDER ADDRESS		
Street		
City	State	Zip Code
Telephone Number	Fax	

Condition Information

1. **Date of Service (mm/dd/yyyy)**
2. **Related Diagnosis Codes**

   Please list below all diagnosis codes related to the Date of Service in #1 above and check YES or NO to indicate whether the condition was diagnosed or medical advice, care or treatment was recommended or provided for the condition during the five (5) years (one (1) year for SpecialCare) prior to the patient's effective date of coverage. If you check Preexisting Condition YES, please provide date of original diagnosis. If the date of original diagnosis is not known, please provide contact information for a medical provider that is able to provide such date.

Diagnosis Code (five digits)	Preexisting Condition	Date of Original Diagnosis if known (mm/dd/yyyy) OR If originally diagnosed or treated by another medical provider: name, address, and telephone number of such provider
	□ YES □ NO	
	□ YES □ NO	
	□ YES □ NO	
	□ YES □ NO	
	□ YES □ NO	

3. Other Diagnosis Codes [First Response Only]

Please complete the table below for any preexisting conditions other than those identified in Question #2 above. If there is insufficient space provided, please attach a copy of this page.

Diagnosis Code (five digits)	Date of Original Diagnosis if known (mm/dd/yyyy) OR If originally diagnosed or treated by another medical provider: name, address, and telephone number of such provider

Certification/Signature

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. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, Highmark may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices.

I certify that the information provided on this form is correct and complete.

Signature_____ Date_____