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: _____

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