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) **Change to Member Records** - Check all boxes that apply.
8) **Change Contract Type** - Check all boxes that apply if the member is changing Contract Type.
9) **Change to Enrollment Status** - Check all boxes that apply if the member is changing enrollment status.
10) **Effective Date** - The effective date of the change.
11) **Please give a brief description of the changes to be made** - Utilize this field to describe any of the changes checked above if further clarification is required.
12) Complete the Street Address, City, State, Zip Code, Home Phone, Work Phone fields only if the Change of Address or Change of Phone boxes are checked.
13) **Employee/Contract Holder** - Complete the appropriate fields in this column to indicate changes that apply to the employee/contract holder.
14) **Spouse/Domestic Partner** - Complete the appropriate fields in this column to indicate changes that apply to the spouse of the employee.
15) **Dependent** - Complete the appropriate fields in these columns to indicate changes that apply to the dependent(s) of the employee.
16) **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.
17) **Previous Member Identification Number** - The Social Security number of the covered individual prior to the change.
18) **Current Member Identification Number** - The new Social Security number of the covered individual.
19) **Previous Last Name** - The last name of the covered individual prior to the change.
20) **Current Last Name** - The last name of the covered individual.
21) **First Name Middle Initial** - The first name and middle initial of the covered individual.
22) **Sex** - The gender of the covered individual.
23) **Member Status** - The relationship of the spouse/domestic partner or dependent children to the employee. Check the appropriate box.
24) **Birthdate** - The birthdate including Month/Day/Year of the covered individual.
25) **Primary Care Physician Name** - Only Managed Care groups should complete this section.
26) **Primary Care Physician Number** - Only Managed Care groups should complete this section.
27) **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.
28) **Marriage Date** - The member's marriage date.
29) **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.

MEMBER CHANGE FORM

HIGHMARK BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

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.

1. Employer Name	2. Employer Telephone Number ( )	3. Association Name (if applicable)		
4. Group Number	5. Employee (Last)	(First)	(M.I.)	6. Member Identification Number

7 - 9. Please check the changes that you need to make to your member records:

- ☐ Change PCP
- ☐ Change of Name
- ☐ Change of Address
- ☐ Change of Phone
- ☐ Change Birthdate
- ☐ Change Hire Date ______
- ☐ Change Report Code
  - Existing: ______
  - New: ______
- ☐ Change in Group Number
  - Existing: ______
  - New: ______
- ☐ Change Identification Number
- ☐ Change Effective Date
- ☐ Add Spouse/Dependent(s)
- ☐ Change Spouse/Dependent Status
- ☐ Delete Spouse/Dependent(s)
- ☐ Change Contract type to (check new contract type)
  - ☐ POS ☐ Comp. ☐ MM ☐ Vision
  - ☐ PPO ☐ FA ☐ PR ☐ Drug
  - ☐ Product Name: ______
- ☐ Change Enrollment Status to
  - ☐ Single ☐ Parent/Children
  - ☐ Insured & Spouse/Domestic Partner
  - ☐ Parent/Child ☐ Family

10. Effective Date of Change	11. Please give a brief description of the changes to be made.

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

12. Street Address	City	State	Zip Code	Home Phone ( )	Work Phone ( )

	13. Employee/Contract Holder	14. Spouse/Domestic Partner	15. Dependent	15. Dependent	15. Dependent
16. 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
17. Previous Member Identification Number	— —	— —	— —	— —	— —
18. Current Member Identification Number	— —	— —	— —	— —	— —
19. Previous Last Name	Last	Last	Last	Last	Last
20. Current Last Name	Last	Last	Last	Last	Last
21. First Name Middle Initial	First M.I.	First M.I.	First M.I.	First M.I.	First M.I.
22. Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
23. Member Status **If your group provides coverage for "Domestic Partner" or "Other", please check the appropriate blue box.**	(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
24. Birthdate	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
25. Primary Care Physician Name					
26. Primary Care Physician Number					
27. Existing Patient?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
28. 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:

Group No: ______ Name of Insurance Carrier: ______

Name of Insured: ______ Identification Number: ______

IMPORTANT: PLEASE READ AND SIGN BELOW: *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.*

29. Employee's Signature and Date ______ Authorization Employer's Signature and Date ______

WHITE AND CANARY: HIGHMARK BLUE SHIELD • PINK: EMPLOYER • GOLDENROD: EMPLOYEE