

## HOW TO COMPLETE YOUR MEMBER CHANGE FORM

Complete the following fields on the Member Change Form. To order additional forms, call 1-800-450-0962.

- 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.**



An Independent Licensee of the Blue Cross and Blue Shield Association

# MEMBER CHANGE FORM

Membership Department  
Fifth Avenue Place  
120 Fifth Avenue  
Pittsburgh, PA 15222



Highmark Blue Cross Blue Shield and Keystone Health Plan West are Independent Licensees of the Blue Cross and Blue Shield Association

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<br>( ) | Association Name (if applicable) |                              |  |
| Group Number  | Employee (Last) | (First)                          | (M.I.)                           | Member Identification Number |  |

Please check the changes that you need to make to your member records:

|  |   |   |   |  |
|--|---|---|---|--|
| <input type="checkbox"/> Change PCP        | <input type="checkbox"/> Change Report Code     | <input type="checkbox"/> Change Identification Number   | <input type="checkbox"/> Change Contract type to (check new contract type)  | <input type="checkbox"/> Change Enrollment Status to                     |
| <input type="checkbox"/> Change of Name    | Existing: _____                                 | <input type="checkbox"/> Change Effective Date          | <input type="checkbox"/> POS <input type="checkbox"/> Comp. <input type="checkbox"/> MM <input type="checkbox"/> Vision         | <input type="checkbox"/> Single <input type="checkbox"/> Parent/Children |
| <input type="checkbox"/> Change of Address | New: _____                                      | <input type="checkbox"/> Add Spouse/Dependent(s)        | <input type="checkbox"/> PPO <input type="checkbox"/> BC <input type="checkbox"/> Dental <input type="checkbox"/> Product Name: | <input type="checkbox"/> Insured & Spouse/Domestic Partner               |
| <input type="checkbox"/> Change of Phone   | <input type="checkbox"/> Change in Group Number | <input type="checkbox"/> Change Spouse/Dependent Status | <input type="checkbox"/> HMO <input type="checkbox"/> BS <input type="checkbox"/> Drug _____                                    | <input type="checkbox"/> Parent/Child <input type="checkbox"/> Family    |
| <input type="checkbox"/> Change Birthdate  | Existing: _____                                 | <input type="checkbox"/> Delete Spouse/Dependent(s)     |   |  |
| <input type="checkbox"/> Change Hire Date  | New: _____                                      |   |   |  |

|                          |  |
|--------------------------|--|
| 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<br>( ) | Work Phone<br>( ) |
|----------------|------|-------|----------|-------------------|-------------------|

| Type of Change                        | Employee/Contract Holder  |   | Spouse/Domestic Partner   |   | Dependent   |   | Dependent   |   | Dependent   |   |
|---------------------------------------|---|---|---|---|---|---|---|---|---|---|
|                                       | <input type="checkbox"/> Add <input type="checkbox"/> Change  | <input type="checkbox"/> Terminate (indicate reason for termination)  | <input type="checkbox"/> Add <input type="checkbox"/> Change  | <input type="checkbox"/> Terminate (indicate reason for termination)  | <input type="checkbox"/> Add <input type="checkbox"/> Change  | <input type="checkbox"/> Terminate (indicate reason for termination)  | <input type="checkbox"/> Add <input type="checkbox"/> Change  | <input type="checkbox"/> Terminate (indicate reason for termination)  | <input type="checkbox"/> Add <input type="checkbox"/> Change  | <input type="checkbox"/> Terminate (indicate reason for termination)  |
|                                       | <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare | <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare | <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare | <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare | <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare   | <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare | <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare   | <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare | <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare   | <input type="checkbox"/> Deceased <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Request Cancel <input type="checkbox"/> Medicare |
| Previous Member Identification Number | —   | —   | —   | —   | —   | —   | —   | —   | —   | —   |
| Current Member 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                                   | <input type="checkbox"/> Male <input type="checkbox"/> Female   | <input type="checkbox"/> Male <input type="checkbox"/> Female   | <input type="checkbox"/> Male <input type="checkbox"/> Female   | <input type="checkbox"/> Male <input type="checkbox"/> Female   | <input type="checkbox"/> Male <input type="checkbox"/> Female   | <input type="checkbox"/> Male <input type="checkbox"/> Female   | <input type="checkbox"/> Male <input type="checkbox"/> Female   | <input type="checkbox"/> Male <input type="checkbox"/> Female   | <input type="checkbox"/> Male <input type="checkbox"/> Female   | <input type="checkbox"/> Male <input type="checkbox"/> Female   |
| Member Status                         | (20) Employee   |   | (01) <input type="checkbox"/> Spouse<br>(29) <input type="checkbox"/> Domestic Partner  |   | (02) <input type="checkbox"/> Child (02) <input type="checkbox"/> Student<br>(02) <input type="checkbox"/> Disabled (05) <input type="checkbox"/> Grandchild<br>(07) <input type="checkbox"/> Nephew (07) <input type="checkbox"/> Niece<br>(17) <input type="checkbox"/> Stepchild |   | (02) <input type="checkbox"/> Child (02) <input type="checkbox"/> Student<br>(02) <input type="checkbox"/> Disabled (05) <input type="checkbox"/> Grandchild<br>(07) <input type="checkbox"/> Nephew (07) <input type="checkbox"/> Niece<br>(17) <input type="checkbox"/> Stepchild |   | (02) <input type="checkbox"/> Child (02) <input type="checkbox"/> Student<br>(02) <input type="checkbox"/> Disabled (05) <input type="checkbox"/> Grandchild<br>(07) <input type="checkbox"/> Nephew (07) <input type="checkbox"/> Niece<br>(17) <input type="checkbox"/> Stepchild |   |
| Birthdate                             | Month / Day / Year  | Month / Day / Year  | Month / Day / Year  | Month / Day / Year  | Month / Day / Year  | 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?                     | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Marriage Date                         | Month / Day / Year  | Month / Day / Year  | Month / Day / Year  | Month / Day / Year  | Month / Day / Year  | 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.

Employee's Signature and Date \_\_\_\_\_ Authorization Employer's Signature and Date \_\_\_\_\_