COMMERCIAL MEMBER CLAIM

Health Net®

STEP 1. *This form may be used for Health Net and Health Net Life Insurance Company products or products offered by your employer group.* Complete the claim form as indicated below. For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Fill out a separate form for each member submitting bills for covered services.** To avoid any delay be sure to answer each question completely. ASK YOUR PHYSICIAN TO COMPLETE THE BACK OF THIS FORM.

SUBMIT TO: **HEALTH NET COMMERCIAL CLAIMS**
P.O. BOX 14702
LEXINGTON, KY 40512

PLEASE ATTACH FULLY ITEMIZED BILLS AND / OR PROOF OF PAYMENT.

SUBSCRIBER INFORMATION - Employee Social Security # must be indicated to assure prompt processing of this request.

SUBSCRIBER NAME LAST	FIRST	MI	SUBSCRIBER SOCIAL SECURITY #

HOME ADDRESS			DATE OF BIRTH (Mo / Day / Yr)	GROUP #

CITY	STATE	ZIP	IS THIS A NEW ADDRESS?	MARITAL STATUS
			❑ Yes ❑ No	❑ Married ❑ Single ❑ Divorced ❑ Widowed

PATIENT INFORMATION

CLAIM IS FOR
❑ Self ❑ Spouse ❑ Daughter ❑ Son ❑ Other (specify) _____

IF SON / DAUGHTER, IS HE OR SHE MARRIED?
❑ Yes ❑ No

SPOUSE / DEPENDENT INFORMATION - Complete below if claim is for employee's spouse or dependent.

NAME LAST	FIRST	MI	DATE OF BIRTH

Is your child dependent upon you for at least half of his or her maintenance and support? ..... ❑ Yes ❑ No
Is he or she a full-time student? ..... ❑ Yes ❑ No

IF DEPENDENT IS A STUDENT, GIVE NAME AND LOCATION OF HIS OR HER SCHOOL	NUMBER OF UNITS

Did you obtain services from a Health Net network physician? ❑ Yes ❑ No

HAVE YOU OR YOUR PHYSICIAN RECEIVED PRECERTIFICATION FOR ALL OR PART OF THE CLAIM? ❑ Yes ❑ No Approx Date _____

ILLNESS / INJURY / PREGNANCY INFORMATION

NAME OF REFERRING PHYSICIAN	DID YOU SELECT THIS PHYSICIAN FROM YOUR NETWORK DIRECTORY? (FOR SELECT, OPTION OR ELECT) ❑ Yes ❑ No

IS THIS PHYSICIAN AFFILIATED WITH YOUR PMG / IPA? (FOR SELECT, OPTION OR ELECT) ❑ Yes ❑ No	IS THE INJURY OR ILLNESS WORK RELATED? ❑ Yes ❑ No If yes, employer's name

DATE ACCIDENT OR ILLNESS OCCURRED	DO YOU BELIEVE YOU ARE COVERED BY OTHER MEDICAL INSURANCE PREVIOUS TO HEALTH NET FOR THIS CONDITION? ❑ Yes ❑ No If yes, give name(s)

OTHER HEALTH INSURANCE INFORMATION

IS PATIENT PRESENTLY COVERED BY OTHER MEDICAL INSURANCE, INCLUDING MEDICARE? ❑ Yes ❑ No	FOR MEDICARE, INDICATE PARTS MEMBER IS ENROLLED IN ❑ Part A ❑ Part B

NAME OF OTHER INSURANCE COMPANY	POLICY #	EFFECTIVE DATE

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP

NAME OF INSURED POLICYHOLDER	SOCIAL SECURITY #	DATE OF BIRTH

EMPLOYER NAME	EMPLOYER ADDRESS	CITY	STATE	ZIP

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

I hereby authorize any physician, health care practitioner, hospital, clinic or other medically related facility to furnish to Health Net, its agents, designees or representatives, any and all information pertaining to medical treatment for purposes of reviewing, investigating or evaluating applications or claims. I also authorize Health Net, its agents, designees or representatives to disclose to a hospital or health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Benefit Agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them to the extent necessary for utilization review or financial audit purposes.

This authorization shall become effective immediately and shall remain in effect as long as Health Net is asked to process claims under my coverage.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

I hereby certify that the above statements are correct.

SIGNATURE OF EMPLOYEE	NAME OF PERSON PREPARING FORM (Please print)	DATE
X		

(Physician Statement on Reverse)

STEP 2. PHYSICIAN STATEMENT:

PLEASE HAVE YOUR PHYSICIAN COMPLETE THE FOLLOWING OR ATTACH AN ITEMIZED BILL, MAKING SURE ALL INFORMATION IS ADDRESSED.

PATIENT INFORMATION (To be completed by the patient)		
1. PATIENT NAME LAST	FIRST	MI

2. RELEASE OF MEDICAL INFORMATION	3. ASSIGNMENT OF MEDICAL BENEFITS
I authorize the release of any medical information necessary to process this claim.	I authorize payment of medical benefits to the undersigned physician or supplier for services described below. This authorization is invalid unless the tax ID # of the provider is given under # 24 below.
SIGNATURE OF PATIENT (parent or guardian if patient is a minor) X — DATE	SIGNATURE OF INSURED OR AUTHORIZED PERSON X — DATE

PHYSICIAN OR SUPPLIER INFORMATION		
4. DATE OF ILLNESS (first symptoms), INJURY (accident), OR PREGNANCY (LMP)	5. DATE YOU WERE FIRST CONSULTED FOR THIS CONDITION	6. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ❑ YES ❑ NO If yes, date(s)
7. DATE PATIENT ABLE TO RETURN TO WORK	8. DATES OF TOTAL DISABILITY From Through	9. DATES OF PARTIAL DISABILITY From Through
10. NAME OF REFERRING PHYSICIAN		11. HOSPITALIZATION DATES FOR RELATED SERVICES Admitted Discharged
12. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)		13. LABORATORY WORK OUTSIDE YOUR OFFICE ❑ None ❑ Yes Charges

14. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

Relate diagnosis to procedure in column D by reference to number 1, 2, 3 or 4 or DX code. Please give CPT-4 procedure code in C and ICD-9 in D below.

1.

2.

3.

4.

A DATES OF SERVICE	B* PLACE OF SERVICE	C – PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED		D DIAGNOSIS CODE	E CHARGES	F (INTERNAL USE)
		PROCEDURE CODE (Identify)	DESCRIPTION (Explain unusual services or circumstances.)			

***PLACE OF SERVICE CODES**

1	H	- Inpatient Hospital	5		- Day Care Facility (Psy)	9	- Ambulance
2	OH	- Outpatient Hospital	6		- Night Care Facility (Psy)	O	OL - Other Location
3	O	- Doctor Office	7	NH	- Nursing Home	A	IL - Independent Laboratory
4	H	- Patient Home	8	SNF	- Skilled Nursing Facility	B	- Other Medical Surgical Facility

15. TOTAL CHARGE

16. AMOUNT PAID

17. BALANCE DUE

18. SIGNATURE OF PHYSICIAN OR SUPPLIER X	19. ACCEPT ASSIGNMENT? (If yes, tax ID # must be given below) ❑ YES ❑ NO	20. PHYSICIAN OR SUPPLIER NAME, ADDRESS, ZIP CODE AND TELEPHONE #
21. DATE	22. PHYSICIAN SOCIAL SECURITY #	
23. YOUR PATIENT ACCOUNT #	24. PHYSICIAN TAX ID #	LICENSE #