Health Net®

Commercial Member Claim

This form may be used for Health Net of California, Inc., Health Net Health Plan of Oregon, Inc. and Health Net Life Insurance Company products or products offered by your employer group. Complete the claim form for each member submitting bills for reimbursement of covered services. To avoid any delay, be sure to answer each question completely.
Please attach fully itemized bills and proof of payment, or ask your physician to complete the back of this form.

Submit to: Health Net of California
Commercial Claims
PO Box 14702
Lexington, KY 40512-4702

For Oregon and Washington
Health Net Health Plan of Oregon, Inc.
Commercial Claims
PO Box 14130
Lexington, KY 40512-4130

Step 1.

Subscriber information – Subscriber # must be indicated to assure prompt processing of this request.

Last name:	First name:	MI:	Subscriber #:	Group #:
Residence address:	City:		State:	ZIP:
Date of birth (Mo / Day / Yr):	Phone #:	Email address:	Marital status: ☐ Married ☐ Single ☐ Domestic partner	

Is the group subject to ERISA? Generally, ERISA applies to all employer health plans. Sole proprietors or partnerships that do not have any employees may not be subject to ERISA. The subscriber group must notify Health Net as changes in ERISA status occur.
☐ Yes, ERISA plan year begins the month of: _____
☐ No, government or public plan or church plan ☐ No, other reason (please specify): _____

Patient information

Claim is for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Daughter ☐ Son ☐ Other (specify):_____

Spouse / Dependent information – Complete below if claim is for spouse or dependent.

Last name:	First name:	MI:	Date of birth:

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:	Is the injury or illness work related? ☐ Yes ☐ No If "Yes," employer's name:	Date accident or illness occurred:

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 ☐ Part D	
Name of other insurance company:	Policy #:	Effective date:	Member ID #:

Insurance company address:	City:	State:	ZIP:
Name of insured policy holder:	Social Security #:	Date of birth:	

Employer name:	Employer address:	City:	State:	ZIP:	Phone #:

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 subscriber: **X**	Name of person preparing form (please print):	Phone #:

(continued)

Step 2. Physician statement:
If you don't have an itemized bill and proof of payment, please have your physician or supplier complete the following sections, making sure all information is addressed.

Patient information (to be completed by the patient)		
Last name:	First name:	MI:
Release of medical information I authorize the release of any medical information necessary to process this claim. Signature of insured or authorized person: Date: (parent or guardian if patient is a minor) **X**	*Assignment of medical benefits* I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signature of insured or authorized person: Date: **X**	

Physician or supplier information		
Date of illness (first symptoms) or injury (accident):	Date you were first consulted for this condition:	Has patient ever had same or similar symptoms? ☐ Yes ☐ No If "Yes," date(s):
Date patient is able to return to work:	Dates of total disability: From: Through:	Dates of partial disability: From: Through:
Name of referring physician:		Hospitalization dates for related services: Admitted: Discharged:
Name and address of facility where services rendered (if other than home or office):		Laboratory work outside your office: ☐ None ☐ Yes Charges:

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[1] Place of service	C – Procedures, medical services or supplies furnished Procedure code (identify)	 Description (explain unusual services or circumstances)	D Diagnosis code	E Charges	F (internal use)

[1]Place of service codes:

11 Doctor office	23 Emergency room	55 Residential substance abuse treatment facility
12 Patient home	24 Ambulatory surgery center	81 Independent laboratory
20 Urgent care facility	31 Skilled nursing facility	99 Other place of service
21 Inpatient hospital	41 Ambulance	
22 Outpatient hospital		

Total charge:

Amount paid:

Balance due:

Signature of physician or supplier: **X**	Accept assignment? ☐ Yes ☐ No (If "Yes," Tax ID # must be given below)	Physician or supplier name, address, ZIP code, and telephone:
Date:	Physician Social Security #:	
Your patient account #:	Physician Tax ID #:	License #:

For your protection, California, Oregon and Washington laws require the following statements to appear on this form.
California: 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.

Oregon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss may be guilty of a crime and may be subject to denial of insurance coverage, fines, civil damages, and confinement in state prison.

Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.