

*This form may be used for Health Net of California 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.*

**STEP 1. SUBMIT TO:** **HEALTH NET COMMERCIAL CLAIMS**  
**P.O. BOX 14702**  
**LEXINGTON, KY 40512**

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.

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

SUBSCRIBER NAME LAST		FIRST		MI	SUBSCRIBER #	
HOME ADDRESS		CITY		DATE OF BIRTH (Mo / Day / Yr)		GROUP #
STATE	ZIP	IS THIS A NEW ADDRESS? <input type="checkbox"/> Yes <input type="checkbox"/> No	PHONE #		MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	

**PATIENT INFORMATION**

CLAIM IS FOR <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other (specify) _____	IF SON / DAUGHTER, IS HE OR SHE MARRIED? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**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? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
Is he or she a full-time student? .....			<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you obtain services from a Health Net network physician? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	FOR MEDICARE, INDICATE PARTS MEMBER IS ENROLLED IN <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D		
NAME OF OTHER INSURANCE COMPANY	POLICY #	EFFECTIVE DATE	MEMBER ID #
INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP
NAME OF INSURED POLICYHOLDER	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 <b>X</b>	NAME OF PERSON PREPARING FORM (Please print)	DATE
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**STEP 2. PHYSICIAN STATEMENT:**

If you don't have an itemized bill and proof of payment, please have your physician complete the following sections 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.	
SIGNATURE OF PATIENT (parent or guardian if patient is a minor)		DATE	SIGNATURE OF INSURED OR AUTHORIZED PERSON
<b>X</b>			<b>X</b>

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? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> None <input type="checkbox"/> Yes Charges

4. 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.)			
<b>*PLACE OF SERVICE CODES</b> 11 Doctor Office      22 Outpatient Hospital      41 Ambulance 12 Patient Home      23 Emergency Room      55 Residential Substance Abuse Treatment Facility 20 Urgent Care Facility      24 Ambulatory Surgery Center      81 Independent Laboratory 21 Inpatient Hospital      31 Skilled Nursing Facility      99 Other Place of Service				15. TOTAL CHARGE	16. AMOUNT PAID	
					17. BALANCE DUE	

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