



# COMMERCIAL MEMBER CLAIM

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

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

### 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			
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) <input type="checkbox"/> Yes <input type="checkbox"/> No
IS THIS PHYSICIAN AFFILIATED WITH YOUR PMG / IPA? (FOR SELECT, OPTION OR ELECT) <input type="checkbox"/> Yes <input type="checkbox"/> No	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	DO YOU BELIEVE YOU ARE COVERED BY OTHER MEDICAL INSURANCE PREVIOUS TO HEALTH NET FOR THIS CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name(s)

### 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	
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 <b>X</b>	NAME OF PERSON PREPARING FORM (Please print)	DATE
-----------------------------------	--	------

**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
<b>2. RELEASE OF MEDICAL INFORMATION</b>		<b>3. ASSIGNMENT OF MEDICAL BENEFITS</b>	
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)	DATE	SIGNATURE OF INSURED OR AUTHORIZED PERSON	DATE
<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

**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.)			
<b>*PLACE OF SERVICE CODES</b>				15. TOTAL CHARGE	16. AMOUNT PAID	
1 H - Inpatient Hospital	5 - Day Care Facility (Psy)	9 - Ambulance			17. BALANCE DUE	
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				

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 #	