health net
MEDICARE PROGRAMS

Medicare Advantage *Member* Claim Form

This form may be used by members to file a claim with Health Net of Arizona, Inc., Health Net of California, Inc., Health Net Community Solutions, Inc., Health Net Health Plan of Oregon, Inc. and Health Net Life Insurance Company. Complete the claim form for each member submitting bills for reimbursement of covered medical 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 Step 2 on pages 2 and 3 of this form.

Step 1: Complete and submit this form to the appropriate address listed for your plan on page 4 of this form. Your plan name can be found on your Health Net Member ID card.

Member information – Member # must be indicated to assure prompt processing of this request.					
Last name:	First name:	MI:	Member #:		Group #:
Residence address:	City:		State:		ZIP:
Date of birth (Mo / Day / Yr):	Phone #:	Email address:			
Marital status: ☐ Married ☐ Single ☐ Domestic partner					
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? ☐ Yes ☐ No					
Name of other insurance company:	Policy #:	Effective date:	Member ID #:		
Insurance company address:	City:		State:	ZIP:	
Name of insured policy holder:	Social Security # (optional):		Date of birth:		
Employer name:	Employer address:	City:	State:	ZIP:	Phone #:

(continued)

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 #:

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 (parent or guardian if patient is a minor): **X** Date:	*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: **X** Date:

Physician or supplier information

Date of illness (first symptoms) or injury (accident):	Date you were first consulted for this condition:	Has patient ever had the 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 were rendered (if other than home or office):		Laboratory work outside your office: ☐ None ☐ Yes Charges:

(continued)

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-10 in D below.
1.
2.
3.
4.

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

[1]**Place of service codes:**

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

Total charge:

Amount paid:

Balance due:

Signature of physician or supplier:

X

Date:

Accept assignment?
☐ Yes ☐ No
(If "Yes," Tax ID # must be given below.)

Physician or supplier name, address, ZIP code, and telephone:

Your patient account #:

Physician Tax ID #:

License #:

Submit this form to the appropriate address listed below. Your plan name can be found on your Health Net Member ID card.

• California:

Health Net of California, Inc. (HMO)
PO Box 14703
Lexington, KY
40512-4703

Health Net Community Solutions, Inc. (HMO and HMO SNP)
PO Box 14703
Lexington, KY
40512-4703

Health Net Life Insurance Company (PPO)
PO Box 14703
Lexington, KY
40512-4703

• Arizona:

Health Net of Arizona, Inc.
PO Box 14730
Lexington, KY
40512-4730

• Oregon/Washington:

(For Oregon and Washington HMO Plans)
Health Net Health Plan of Oregon, Inc.
PO Box 14130
Lexington, KY 40512

Health Net Life Insurance Company (PPO)
PO Box 14130
Lexington, KY 40512

If you have any questions about your Health Net membership, please call Health Net Member Services. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, your call will be handled by our automated phone system on weekends and certain holidays.

- Arizona: 1-800-977-7522 (TTY: 711)
- California: (HMO) 1-800-275-4737, (PPO) 1-800-960-4638, (HMO SNP) 1-800-431-9007 (TTY: 711)
- Oregon/Washington: 1-888-445-8913 (TTY: 711)

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

Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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.

Health Net has a contract with Medicare and the Arizona and California state Medicaid programs, to offer HMO, PPO and HMO SNP coordinated care plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal. Health Net of Arizona, Inc., Health Net of California, Inc., Health Net Community Solutions, Inc., Health Net Health Plan of Oregon, Inc., and Health Net Life Insurance Company are subsidiaries of Health Net, Inc. Health Net is a registered service mark of Health Net, Inc.

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