Out-of-Network Claims Questionnaire

Please provide all of the requested information below. Remember to attach an itemized bill for each out-of-network claim you are submitting for review. If you have any questions, please call us at the customer service number on your Health Net ID card.

1. Patient's Health Net ID#
___ ___ ___-___ ___-___ ___ ___ ___

2. Patient's Date of Birth
___ ___/___ ___/___ ___

3. Patient's Name

4. ☐ Male ☐ Female

5. Member's Address City State Zip

6. The **daytime phone number** where you may be reached if we have more questions:
(___ ___ ___) ___ ___ ___-___ ___ ___ ___

7. Is the patient a **full-time student out of the service area?**
☐ Yes ☐ No

8. If the attached claim has been caused by an **automobile accident,** please submit this and all related claims to your no-fault insurance carrier.

   If the attached claim has been caused by the **patient's employment,** please submit this and all related claims to the employer's Worker's Compensation carrier.

   If Health Net is your **secondary insurance plan,** please submit this claim to your primary insurance carrier.

   Once a determination has been made by either No-Fault, Worker's Compensation or another primary insurance carrier, submit a copy of the original bill and a copy of their explanation of benefits to Health Net for further consideration.

9. Please provide a detailed explanation as to the **specific nature of illness or injury** and **why a Health Net physician/provider was not utilized.** (Please attach additional pages if needed.)

   _____

   _____

Vision Care Hardware Reimbursement

Vision Care Provided: DX V720

Please Check Purchase:

_____ Prescribed Lenses – V2118 _____ Frames – V2020 _____Prescribed Contact Lenses – V2500

Amount Paid: $ _____ **- Copy of paid and dated receipt required.**

NOTE: The Vision Care Benefit reimburses for vision hardware as outlined in the EOC.

10. If you want us to pay covered benefits directly to the provider, sign and date the authorization below. If authorized, we will make payment directly to your provider and send a copy of the payment to you for your records.

    I authorize payment of medical benefits **directly** to physician or supplier for attached services.

    Signed _____ Date _____

Please send claims and written inquires to:
ACS/Health Net
P.O. Box 14700
Lexington, KY 40512

Members: If you have any questions regarding claims please call the customer service number on your ID Card.

Providers: call (800) 894-8884

Note: Claim information should be submitted on a completed HCFA-1500 or UB-92 form.