Health Insurance Claim Form

Health Net®

PATIENT INFORMATION	EMPLOYEE (INSURED) INFORMATION	OTHER INSURED INFORMATION
1a PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	4a EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)	IF THE PATIENT HAS ANY OTHER HEALTH INSURANCE (INCLUDING MEDICARE) PLEASE COMPLETE THE FOLLOWING ITEMS.
		7 OTHER INSURED'S NAME (LAST, FIRST, MIDDLE INITIAL)
1b ADDRESS (STREET, CITY, STATE, ZIP CODE)	4b ADDRESS (STREET, CITY, STATE, ZIP CODE)	
		8a BIRTHDATE MO _____ DAY _____ YR _____
		8b SEX ❑ MALE ❑ FEMALE
1c TELEPHONE #	4c TELEPHONE #	9a SOCIAL SECURITY #
2a BIRTHDATE MO _____ DAY _____ YR _____	5a SOCIAL SECURITY #	9b INSURANCE PLAN NAME
2b SEX ❑ MALE ❑ FEMALE	5b BIRTHDATE MO _____ DAY _____ YR _____	10 GROUP NUMBER OR NAME
3a RELATIONSHIP TO EMPLOYEE ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER	5c SEX ❑ MALE ❑ FEMALE	11a MEMBER #
3b STATUS ❑ SINGLE ❑ MARRIED ❑ OTHER ❑ EMPLOYED ❑ FULL-TIME STUDENT ❑ PART-TIME STUDENT	6a EMPLOYEE'S GROUP NUMBER OR NAME	11b ADDRESS OF OTHER INSURANCE PLAN
3c IS THE PATIENT A CHILD, UNMARRIED, AND DEPENDENT PRIMARILY ON THE EMPLOYEE FOR SUPPORT? ❑ YES ❑ NO	6b INSURANCE PLAN NAME	
3d IS THE PATIENT'S CONDITION RELATED TO ANY OF THE FOLLOWING? EMPLOYMENT ❑ YES ❑ NO; AUTO ACCIDENT ❑ YES ❑ NO; OTHER ACCIDENT ❑ YES ❑ NO		
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. TO THE BEST OF MY KNOWLEDGE, THIS CLAIM FORM DOES NOT CONTAIN ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION. SIGNED _____ DATE _____		13 INSURED OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR THE SERVICE DESCRIBED BELOW. SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ❑ YES ❑ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ❑ YES ❑ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN # GRP #

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE PRINT OR TYPE

To submit a claim:

Use a separate claim form for each family member.

Fill out items 1-13 on trhe front of this form.

Attach itemized bills that include:
- Patient name
- Doctor name and address
- Date of service
- Diagnosis
- Amount charged for each service rendered

If you do not have itemized bills ask your doctor or supplier to fill out items 14-33.

Mail your claim and itemized bills to: ACS/Health Net of Arizona
Claims Department
P.O. Box 14225
Lexington, KY 40512-4225

If you have questions:

Call a Customer Service representative: 1-800-289-2818

Place of service codes

11	Office
12	Home
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room — hospital
24	Ambulatory surgical center
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance — land
42	Ambulance — air or water
51	Inpatient psychiatric facility
52	Psychiatric facility — partial hospitalization
53	Community medical center
54	Intermediate care facility — mentally retarded
55	Residential substance abuse treatment center
56	Residential psychiatric center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End-stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Independent laboratory
99	Other unlisted facility

Type of service codes

1	Medical care
2	Surgery
3	Consultation
4	Diagnostic X-ray
5	Diagnostic laboratory
6	Radiation therapy
7	Anesthesia
8	Assistance to surgery
9	Other medical service
0	Blood or packed red cells
A	Used DME
M	Alternate payment for maintenance dialysis
Y	Second opinion on elective surgery
Z	Third opinion on elective surgery