



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. <input type="checkbox"/> Male <input type="checkbox"/> 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 ? <input type="checkbox"/> Yes <input type="checkbox"/> 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.) _____ _____			
Members: If you have any questions regarding claims please call the customer service number on your ID Card. Providers: call (800) 438-7886 Note: Claim information should be submitted on a completed HCFA-1500 or UB-92 form.			

Out-of-network services are underwritten by a subsidiary of Health Net of the Northeast. In New York, services may be underwritten by The Guardian Life Insurance Company of America.