



**Health Net**  
Formerly PHS Health Plans

# Chiropractic Claims Only Out-of-Network Claims Questionnaire

Please provide all of the requested information below. This will help us in expediting the review of your claim(s). Please remember to include an itemized bill for each out-of-network claim you are submitting for review. We appreciate your assistance in this process. If you have any questions, please call us at the number listed below.

1. Please indicate the name, address, and Health Net ID number of the patient.

Patient Name: \_\_\_\_\_ Health Net ID #: \_\_\_\_\_

Address: \_\_\_\_\_

2. If Health Net is your secondary insurance plan, an Explanation of Benefits from your primary carrier must be included with the bill or claim form.

3. Please answer the following questions to help us process your bill or claim form as quickly as possible:

• Are you a college student away from home?  Yes  No

• **If this was an emergency, please provide a detailed explanation as to the specific nature of the illness or injury and why a PHS physician/provider was not utilized. (Please attach additional pages if needed.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• Is this injury related to an automobile accident?  Yes  No If yes, date of injury: \_\_\_\_\_

• Is this injury related to your job?  Yes  No If yes, date of injury: \_\_\_\_\_

If YES to either question, please forward all related claims to your No-Fault insurance carrier, if applicable, or to your employer's Workers' Compensation insurance carrier prior to submitting them to Health Net for review.

• Did this illness or injury require inpatient hospitalization?  Yes  No

If YES, please indicate: Name of Hospital/Facility: \_\_\_\_\_  
Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

• If not an emergency, did a Health Net physician request services from this non-Health Net physician or facility?  Yes  No

• **Did you pay for these services already?**  Yes  No

If YES, enclose the original receipt(s), if available, along with the original itemized bill(s). If approved, we'll reimburse you directly for these services. If NO, we will pay the provider(s) directly on your behalf if the provider is not located within the Health Net service area.

• Please indicate the daytime phone number where you may be reached if we have more questions: (\_\_\_\_) \_\_\_\_\_

<b>MEMBERS</b>	
If you have any questions regarding out-of-network claims, please Health Net/Landmark's CUSTOMER RELATIONS DEPARTMENT: 1-800-638-4557	
Send written inquiries to:	Health Net/Landmark 1750 Howe Avenue Suite 400 Sacramento, CA 95825
NOTE: Claim information should be submitted on a completed HCFA-1500, UB92 or UBF form.	

<b>PHYSICIANS/PROVIDERS</b>	
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