



Mental Health 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 Health Net 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: (____) _____

MEMBERS

If you have any questions regarding out-of-network claims, please call HealthNet/MHN's CUSTOMER RELATIONS DEPARTMENT at The phone number listed on the back of your ID card.

Send written inquiries to:

MHN/ACS
P. O. Box 14621
Lexington, KY 40512-4621

NOTE: Claim information should be submitted on a completed HCFA-1500, UB92 or UBF form

PHYSICIANS/PROVIDERS

If you have any questions regarding out-of-network claims, please call Health Net/MHN's OUT-OF-NETWORK CLAIMS DEPARTMENT:
1-800-583-2990

Please send written inquiries and claims to:

MHN/ACS
P. O. Box 14621
Lexington, KY 40512-4621

NOTE: Claim information should be submitted on a completed HCFA-1500, UB92, or UBF form.