MHN
A Health Net Company℠

Commercial Member Claim

(This form is not applicable for Medicare Claim)

This form may be used for all MHN Claims including Managed Health Network and MHN Services. Complete the claim form for each member submitting bills for reimbursement of covered services. To avoid any delay, be sure to answer each question completely.

Step 1.
Please attach fully itemized bills and proof of payment or ask your health care practitioner to complete the back of this form. Then submit the completed form with attachments to: MHN Claims
P.O. Box 14621
Lexington, KY 40512-4621

Subscriber information – Subscriber # must be indicated to assure prompt processing of this request.					
Last name:	First name:	MI:	Subscriber #	Group #:	
Residence address:	City:		State:	ZIP:	
Date of birth (Mo /Day/ Yr):	Phone #:	Email address:	Marital status: ☐ Married ☐ Single ☐ Domestic partner		

Patient

Claim is for:
☐ Self ☐ Spouse ☐ Domestic partner ☐ Daughter ☐ Son ☐ Other (specify) _____

Patient information - Complete below if claim is for spouse, partner or dependent.			
Last name:	First name:	MI:	Date of Birth:

Did you obtain services from a MHN network health care practitioner? ☐ Yes ☐ No

Have you or your health care practitioner received precertification for all or part of the claim? ☐ Yes ☐ No Approx date:

Other health insurance information

Is/Was patient covered by other medical insurance, including Medicare? ☐ Yes ☐ No		For Medicare, indicate parts member is enrolled in: ☐ Part A ☐ Part B ☐ Part D	
Name of other insurance company:	Policy #:	Effective date:	Member id #:

Insurance company address:	City:	State:	ZIP:
Name of insured policy holder:	Social Security #:	Date of birth:	

Employer name:	Employer address:	City:	State:	ZIP:	Phone #:

Authorization to obtain and release medical information

I hereby authorize any health care practitioner, hospital, clinic or other medically related facility to furnish to Health Net/ MHN, its agents, designees or representatives, any and all information pertaining to medical treatment for purposes of reviewing, investigating or evaluating applications or claims. I also authorize Health Net/MHN, its agents, designees or representatives to disclose to a hospital or health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a Group Benefit Agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them to the extent necessary for utilization review or financial audit purposes. This authorization shall become effective immediately and shall remain in effect as long as Health Net/MHN is asked to process claims under my coverage. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby certify that the above statements are correct.

Signature of subscriber or adult dependent: **X**	Name of person preparing form (please print):	Phone #:

(Practitioner statement on reverse)

Step 2. Health care practitioner statement:
If you don't have an itemized bill and proof of payment, please have your health care practitioner or supplier complete the following sections, making sure all information is addressed.

Patient information		
Last name:	First name:	MI:

Health care practitioner information (to be completed by practitioner)		
Name of referring health care practitioner:	Laboratory work outside your office: ☐ None ☐ Yes	Hospitalization dates for related services: Admitted: Discharged:

List the diagnosis code for the services rendered below, then place 1,2,3 or 4 as applicable, in D- Diagnosis Code Pointer. The CPT code goes in C- Procedure Code.		ICD Indicator: ☐ ICD 9 ☐ ICD 10
1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

A Dates of service	B [1] Place of service	C – Procedures, medical services or supplies furnished		Units	D Diagnosis Code Pointer	E Charges
		Procedure code (identify)	Description (explain unusual services or circumstances)			

Some common [1] Place of service codes: (not a complete list)
11 Doctor office
12 Patient home
20 Urgent care facility
21 Inpatient hospital
22 Outpatient hospital
23 Emergency room
31 Skilled nursing facility
41 Ambulance
55 Residential substance abuse treatment facility
81 Independent laboratory
99 Other place of service

Total Charge:	0.00
Amount Paid:	
Balance due:	

Name and address of facility where services rendered (if other than home or office):			Health care practitioner name, office address and telephone:
Signature of health care practitioner: **X**	Accept Medicare assignment? ☐ Yes ☐ No		
Date :	Practitioner NPI #:		
Patient account #:	Practitioner Tax id #:	License #:	

For your protection, Arizona, California and Washington laws require the following statements to appear on this form.
Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
California: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Oregon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss may be guilty of a crime and may be subject to denial of insurance coverage, fines, civil damages and confinement in state prison.
Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.