Health Net®

One Far Mill Crossing ■ P.O. Box 904 ■ Shelton, CT 06484-0944 ■ www.health.net

Fax to: Health Net® Customer Service
Attn: Predetermination of Fees
Fax #: 203-402-7056

Date: _____

Request for Predetermination of Fees

Health Net® would like to assist you with your request to obtain a predetermination of fees for services rendered by a non-participating provider. In order to process your request, please complete all the following information and fax this form back to the number listed above. **All information must be filled in completely, or Health Net will not be able to reply to your request.**

Patient Name: _____ Health Net ID#: _____

Address: _____

City: _____State: _____ Zip Code: _____

Date Services are to be performed: _____

Provider Name: _____ Telephone #: _____

Address: _____

City: _____State: _____ Zip Code: _____

Procedure Code(s) to be billed:	Dollar Amount to be billed for each procedure:
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

Diagnosis: _____

Please allow seven (7) business days for Health Net to process this request from the date of receipt.