Health Net®

PROVIDER INQUIRY REQUEST

This form should not be used if you wish to submit a provider dispute requesting Health Net's reconsideration of a claim denial or adjustment; request for reimbursement of overpayment; or other contract issue. For provider disputes, use the Provider Dispute Resolution Request form. Send completed Provider Inquiry Requests to:

Health Net
P.O. Box 9103
Van Nuys, CA 91409-9103

Health Net Medi-Cal Provider Services Center
11971 Foundation Place
Rancho Cordova, CA 95670

Medi-Cal Contested Claims
Health Net Medi-Cal Claims Department
P.O. Box 1630
Rancho Cordova, CA 95741-1630

Sent by:	**PROVIDER TAX ID #:**
Provider Name: (hospital/facility/physician)	**PROVIDER ID #:**
	Medicare ID #: (if appropriate)
PROVIDER ADDRESS:	

Patient Name:		Date of Birth:
Member ID Number:	Claim ID Number: (if known)	
Service "From/To" Date:	Original Claim Amount Billed:	Date Sent:

INDICATE REASON FOR INQUIRY AND PROVIDE A DETAILED DESCRIPTION:

Inquiry Type:

- ☐ **Resubmission of contested claim with missing information (requested individual claim documents attached**
- ☐ **Status of claim (for example, no receipt of payment)**
- ☐ **Clarification on calculation of payment**
- ☐ **Assistance in determining member responsibility**
- ☐ **Corrected billing (additional charges previously not submitted)**

SPREADSHEET ATTACHED:

- ☐ **YES**
- ☐ **NO, individual claim(s) attached**

Contact Name (please print) _____ Title _____ Telephone Number _____

Signature _____ Date _____

Updated 1/09