



(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 – S	Subscriber # must he ind	icated to assure	nromnt nroce	essino of	this reau	est				
Last name:	First name:				Subscriber # Group #:			Group #:		
Residence address:		City:				State	e:		ZIP:	
Date of birth (Mo /Day/ Yr	Email addre	Email address:			Marital status: ☐ Married ☐ Single					
	Phone #:		Email address.				☐ Domestic partı			
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? For Medicare, indicate parts member is enrolled in:										
☐ Yes ☐ No					Part B Part D					
Name of other insurance company: Poli			Effe			Effective date:			Member id #:	
Insurance company addres		City:					State:	ZIP:		
Name of insured policy ho		Social Security #:					Date of birth:			
Employer name:	Employer address:		City: State:		Z	IP:	Phone #:			
A 17	1 1 1 1									
Authorization to obtain and I hereby authorize any hea			than madiaali	les malatas	1 facility	to fra	nich to II.	aalth Mat	/ MIIN ita	
									WITHIN, ILS	
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	Name of	Name of person preparing form (please			print)	):	Phone 7	#:		
X										

(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 info	ormation										
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:       Hospitalization dates for related services:											
			□ None □ Yes				Discharged:				
*			7		2 2 4				ei com		
List the diagnosis code for the services rendered below, then place 1,2,3 or 4 as applicable, in D- Diagnosis Code Pointer. The CP											
0					ICD Indic	CD Indicator: ☐ ICD 9 ☐ ICD 10					
1.			5. 9.								
2.			6. 10.								
3.			7. 11. 8. 12.								
4.	B¹	C - Proced		modical services	or supplies furn		Units	D	E		
Dates of	Place of	Procedure	dures, medical services or supplies furnished					Diagnosis	Charges		
service	service	code		Description (explain unusual services or circumstances)				Code	onar goo		
		(identify)		Circuit	Circumstances)			Pointer			
		(idoitiny)									
~	4.70										
Some common <sup>1</sup> Place of service codes: (not a complete list)						Total (	Total Charge:				
11 Doctor office 23 Emergency room 81 Independent laboratory 12 Patient home 31 Skilled nursing facility 99 Other place of service						Amount Paid:					
20 Urgent care facility 41 Ambulance						Amou	nt Paid:				
21 Inpatient hospital 55 Residential substance abuse						Balance due:					
22 Outpatient hospital treatment facility						Dalaik	Balance due.				
Name and address of facility where services rendered (if other than home or office):						Health	Health care practitioner name,				
Thank and address of fashing where set these femocres (it offer than home of office).							office address and telephone:				
Signature of health care practitioner: Accept Medicare assignment?   Yes  No								•			
X											
Date:			I	Practitioner NPI#:							
Patient account #:			I	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.