MEMBER CLAIM

Fill out a separate form for each member submitting bills for covered services.
MAIL COMPLETED FORM WITH BILLS, PROOF OF PAYMENT, AND MEDICARE'S SUMMARY NOTICE SHOWING PRIMARY COVERAGE TO:

HEALTH NET MEDICARE SUPPLEMENT CLAIMS
PO BOX 14702
LEXINGTON, KY 40512

PLEASE TYPE OR PRINT

SUBSCRIBER INFORMATION

SUBSCRIBER #	SUBSCRIBER SSN MUST BE INDICATED TO ASSURE PROMPT PROCESSING OF THIS REQUEST	NAME LAST	FIRST	MI	BIRTH DATE (Mo/Day/Yr)

ADDRESS	CITY	STATE	ZIP	TELEPHONE #
				( )

PATIENT INFORMATION

NAME LAST	FIRST	MI	BIRTH DATE	GROUP #

MEDICAL SERVICES RECEIVED OUTSIDE OF THE U.S.? ❑ YES ❑ NO

IS THIS ILLNESS OR INJURY WORK RELATED? ❑ YES ❑ NO

IF YES, INDICATE DATE OF INJURY AND EMPLOYER NAME
(DATE) (NAME)

OTHER HEALTH INSURANCE (do not include Medicare in this section)

IS PATIENT PRESENTLY COVERED BY OTHER MEDICAL INSURANCE INCLUDING MEDI-CAL (DO NOT INCLUDE MEDICARE)? ❑ YES ❑ NO

IF YES, PLEASE COMPLETE THIS SECTION

OTHER INSURANCE COMPANY NAME

ADDRESS	CITY	STATE	ZIP	POLICY #	EFFECTIVE DATE

NAME OF INSURED POLICYHOLDER	BIRTH DATE (Mo/Day/Yr)	EMPLOYER NAME

EMPLOYER ADDRESS

Use this portion to report services covered by your Medicare Supplement Plan, but not covered by Medicare. Attach a bill or photocopy. Please be sure that duplicate bills are not submitted. Please also attach the Explanation of Benefits received by Medicare, if applicable.

DATE OF SERVICE Mo/Day/Yr	PROVIDER OF SERVICE (Doctor, Lab., Ambul. Comp., R.N., etc.)	DESCRIPTION OF SERVICES RENDERED	ILLNESS OR DIAGNOSIS	TOTAL CHARGE	AMOUNT PAID BY YOU

NAME OF PERSON TO RECEIVE PAYMENT OR REIMBURSEMENT

NAME OF PERSON PREPARING FORM (PLEASE PRINT)	DATE	SUBSCRIBER SIGNATURE
		X

6004176 (2/03)