Health Net®

OUT OF NETWORK CLAIM FORM

Most Health Net Vision plans allow members to select the provider of their choice, in or out of the network. Health Net Vision has designed benefit plans to deliver the quality care, matched with comprehensive benefits, at the most affordable cost, through our in-network services. Members also have the flexibility to visit an out-of-network provider, with a reduction in benefits. Please consult your member benefits information to ensure coverage of non-participating provider services.

The Health Net Vision Network includes many eye care professionals in your area; before submitting an out-of-network claim form for services, please consult with your eye care provider to confirm whether or not he/she participates on the Health Net Vision network, please consult with the provider office regarding the submission of your vision claim.
If you choose to go to an Out of Network provider, please complete the following steps prior to submitting your Out of Network claim form. Any missing or incomplete information may result in a delay in receiving payment or be returned to you. Please Note: This form is only for services received after January 1, 2004. For information about filing a claim for services before January 1, 2004, please contact Health Net at the number on your Health Net ID card.

1. When you choose a non-participating provider to receive vision care services, you are responsible for payment of vision care services at the time of service. Health Net Vision will reimburse you for authorized services according to your plan design. Please consult your plan design for the listing of qualified services and their reimbursement amounts.
2. Complete ALL Sections of the form to ensure proper benefit allocation.
3. Complete the Plan Information Portion of your claim form. This information can be found on your benefit card or by contacting your Human Resources Department. You may substitute a photocopy of your benefit card.
4. Complete the Request for Reimbursement section. Health Net Vision will only accept itemized paid receipts that indicate the services provided and the amount charged for each service. Handwritten receipts must be on provider letterhead.
5. Sign the claim form
6. Attach itemized paid receipts from your provider to the claim form. If the paid receipt is not in US dollars, please identify the currency in which the receipt was paid.

DATE OF SERVICE	Claim Number/Authorization

PATIENT INFORMATION

NAME LAST	FIRST	MI

ADDRESS

CITY	STATE	ZIP CODE

DAYTIME PHONE	DATE OF BIRTH

PLAN INFORMATION

SUBSCRIBER NAME LAST	FIRST	MI	DATE OF BIRTH

PLAN NAME

SUBSCRIBER ID

REQUEST FOR REIMBURSEMENT

AMOUNT CHARGED FOR SERVICES **(Remember to include itemized receipts)**

EXAM	CONTACTS (Included Fit/Followup)	LENS	FRAMES
$	$	$	$

Type of Lens (Please check lens type purchased) ❑ Single ❑ Bifocal ❑ Trifocal ❑ Progressive

I hereby understand that without prior authorization from Health Net Vision for services rendered, I may not be reimbursed for submitted vision services I am ineligible for. I hereby authorize any Insurance Company, Organization Employer, Ophthalmologist, Optometrist and Optician to release any information with respect to this claim. I CERTIFY THAT the information furnished by me in support of this claim is true and correct.

MEMBER / PATIENT SIGNATURE (Not a Minor)	DATE

Please mail the claim to:
Health Net Vision
Attn OON CLAIMS
P.O. Box 8504
Mason, OH 45040-7111

To Fax Information: **(866) 293-7373**
If the fax transmission is illegible, it will be returned to the sender via the same fax number.
If you need assistance, please call Health Net Vision at (866) 392-6058