Health Net Therapy Fax Request Form

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PLEASE USE THIS FORM FOR ALL HEALTH NET MEMBERS

Health Net

Fax Date: _____# of Pages Faxed: _____ **Please fax to OrthoNet at: (800) 450-4189**

THERAPY PROVIDER INFORMATION

Facility Name

Street Address

City **State** **Zip**

Telephone Number ( ) -

Return Fax Number ( ) -

Health Net Provider ID Number

Provide OrthoNet ID # OR Health Net ID # IF NOT PAR with OrthoNet

OrthoNet Provider ID Number

Individual Therapist Code

PATIENT INFORMATION

First Name

Last Name

Date of Birth / /
Month Day Year

Health Net Plan
- ○ Passport/Charter
- ○ Smart Choice
- ○ Healthy Options

H N

Patient ID Number

REQUEST INFORMATION

Request for:
- ○ Therapy Visits Pre-Certification
- ○ Other Procedure: _____

Service Type
- ○ Physical Therapy
- ○ Occupational Therapy

Is this request for post-operative therapy visits?
- ○ Yes ○ No

Initial Evaluation Date / /
Month Day Year

Diagnosis Code (i.e. 8430 or V4365)

Requested # of Visits

Instructions:

1. Use this form as a Fax Cover Sheet and send all supporting clinical data with this request.
2. Please ensure that this form is a DIRECT COPY from the MASTER.
3. Please PRINT, in black ink, one character per box for ALL requested information and completely fill in each circle that represents the corresponding NUMBER entry where applicable.
4. For assistance in completing this form, please call OrthoNet Provider ServicesToll Free at (800) 413-8695.

OrthoNet

For Internal Office Use Only
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