HNS FAX INQUIRY FORM

PROVIDER'S INFORMATION	HNS TO COMPLETE
Today's Date:	Date Received by HNS:
Provider's Name: Dr.	Date Response Sent:
Fax:	Response Prepared By:
Phone:	Fax Number: (877) 329-2620
Number of Pages:	Number of Pages:
Contact Person:	HNS Provider Rep:

☐ Should claims for the attached member ID card be filed to HNS?

☐ What information from the attached member ID card should be in boxes 11, 11b, & 11c?

☐ Change of Practice Information – please fax a Practice Change Form to our office.

☐ The patient and date of service circled on the attached EOB (and remittance statement) isn't a patient at this office. Please adjust accordingly.

☐ Please check the status of the following **primary** claim(s). Has HNS received the claim(s)?

☐ Please check the status of the following **secondary** claim(s). Has HNS received the claim(s)?

Name:	Name:
ID #:	ID #:
Ins Plan:	Ins Plan:
Date of Birth:	Date of Birth:
Date(s) of Service:	Date(s) of Service:

Additional Comments or Questions:

Visit our website at http://www.healthnetworksolutions.net

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