



Health Net Office Only:
Received by: _____
Date Received: _____
Date Processed: _____

Individual & Family Plans Accident Waiver Deductible Request

This form must be received by Health Net Life within 60 days of the accident date of service. Please refer to your Policy for details on the accident waiver. Please fill in all information below in blue or black ink. Incomplete requests will not be processed.

Member's Last Name:		Member's First Name:		Member's M.I.:	Member's Date of Birth:
Member's Address:			City:	State:	ZIP Code:
Member's Social Security Number:		Member's Plan Name (available on ID card):		Member's Group ID (available on ID card):	
Date of Accident: ____/____/____	Date of Service: ____/____/____	Place of Service:		Provider:	
How did the accident occur? Please provide as much detail as possible.					

Please attach a copy of your Explanation of Benefits (EOB) for the service above and mail to the following address:

**Health Net Claims Unit
P.O. Box 14702
Lexington, KY 40512**

Your request will be processed within four (4) weeks of receipt date. You will receive communication regarding this claim if your request is denied. For questions, please call Member Services at 1-800-839-2172.