HNS FAX INQUIRY FORM

Provider 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:

Email is a more efficient way to communicate.

Please consider emailing your HNS Service Representative with your questions or concerns.

☐ 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:

THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED. THIS COMMUNICATION MAY CONTAIN INDIVIDUAL PROTECTED HEALTH INFORMATION ("PHI") THAT IS SUBJECT TO PROTECTION UNDER STATE AND FEDERAL LAWS, OR OTHER PRIVILEGED, CONFIDENTIAL OR PROPRIETARY INFORMATION OF HEALTH NETWORK SOLUTIONS, INC THAT MAY NOT BE DISCLOSED. IF YOU ARE NOT THE INTENDED RECIPIENT, OR THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING THIS COMMUNICATION TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY REPLYING TO THIS FAX AND SHRED IT ONCE FAX CONFIRMS. THANK YOU.

Revised 081617