HIPAA Form – For help finding proof in Health Net Settlement.

For Group B and Group C Claims only - Otherwise disregard this form.

If you are submitting any GROUP B and/or GROUP C claims, AND you want the claims administrator to try to get supporting documentation for you from your health care provider(s) - you must fill out one of these forms for each provider you would like contacted. You can download more forms at www.healthnetclassaction.com, or photocopy this form before filling it out. Mail the completed form(s) to Health Net Class Action Litigation, c/o Berdon Claims Administration LLC, at P.O. Box 9007, Jericho, NY 11753-8917, postmarked on or before **April 10, 2015**. Questions? Call Berdon at 1-800-766-3330.

Authorization to Release Health Care Billing Information

Patient Name:___________________________________

I, ____, give permission to the Out-Of-Network Provider listed below, to release health care billing information to Berdon Claims Administration LLC, P.O. Box 9007, Jericho, NY 11753-8917, for services I received on:

Date of Service: ______/______/_______ Date of Service: ______/______/_______

Date of Service: _____/______/________ Date of Service: _____/______/________

I understand that I am granting this authorization under the Health Insurance Portability and Accountability Act (HIPAA). I understand that I have the right to revoke this Authorization, in writing, at any time by so notifying Berdon. Such revocation will not affect actions taken by Berdon prior to the date it receives the written revocation.

Signature: ________________________________ Date: ________________________

Print Name: ___________________________________ Home Address: ____

City: _____________________________________ State: ___________ Zip : _________________________

Day Time Telephone Number: ( ) ______________________ Email Address: ___________________________________

Reference Number that appears on your Blue Sheet: _______________

If signed by patient's authorized representative, describe the representative's authority (check one):

________ Patient is a minor; I am the patient's parent ________ Patient is a minor: I am the patient's guardian

________ Patient is deceased. I am the patient's surviving spouse or I am the executor or administrator of the patient's estate.

________ Other (please describe): ____

PROVIDER INFORMATION

Provider Name: ____

Provider Address: ____

Provider City: ________________________________ State: ___________ Zip: ______________________

Provider Phone Number: ( ) _____________________ Provider Fax Number: ( ) ________________________