



health net

### ECM and Community Supports Invoice Claim Form

Important: Complete a separate invoice form for each member who received covered services. To avoid processing delays, please ensure completion of the fields with \* on this form.

Options for Submitting:

**Mail:**  
Health Net – Cal AIM Invoice  
PO Box 10439, Van Nuys, CA 91410-0439  
**Fax:** (833) 386-1043

**Email:**  
[CalAIM\\_CS\\_invoicesubmission@centene.com](mailto:CalAIM_CS_invoicesubmission@centene.com)  
**Upload PDF:**  
<https://CalAim.portal.conduent.com/>

**Section 1a: Billing Provider Information**

*National Provider Identifier (NPI):		*Tax Identification Number (TIN):	
*Provider’s last/Organization name:			
Provider’s first name:			
*Address:		*City:	
*State:	*ZIP:	*Phone number:	

**Section 1b: Rendering Provider Information**

National Provider Identifier (NPI):		*Tax Identification Number (TIN):	
*Provider’s last/Organization name:			
Provider’s first name:			
*Address:		*City:	
*State:	*ZIP:	*Phone number:	

**Section 2: Member Information - Please complete a separate form for each member who received services.**

*Member Client Identification Number (CIN):		Member Homeless Indicator:	
*Last name:	*First name:	*Date of birth (Mo./Day/Yr.):	
*Residential address:			
*City:		*State:	*ZIP:
*Insured’s or Authorized Person’s Signature. I authorize payment of Community Supports services to the undersigned physician or supplier for services described below.			

**Section 3: Service & Billing Information**

*Payor Primary ID:					Payor Name:					
*Diagnosis Codes	*A:	*B:	*C:	*D:	*E:	*F:	*G:	*H:	*I:	*J:

Service Options										*Service unit
#	*Service start date	*Service end date	*Place of service	Service name	*Procedure	*Modifier(s)	*Diag #	*Count	*Cost	*Charge amount
1										
2										
3										
4										
5										
6										
<b>Invoice Amount</b>										

**Section 4: Administrative Information**

*Invoice Date (Mo./Day/Yr.):		*Invoice #:	Control #:	Attachments:
Authorization ID #:		Submission Type:		Original Claim ID:
*Signature of Physician or Supplier (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				
*Signed:			*Date:	