Health Net of California, Inc

Confidential - Protected Health Information

HEALTH NET MEMBER GRIEVANCE FORM

Name: _____Date: _____

Subscriber Identification Number: _____ Group Number: _____

Address:
_____
_____
_____
_____
Daytime Telephone No. _____
_____
Participating Physician Group: _____
_____

Please explain in detail the circumstances that led to your dissatisfaction with Health Net of California, Inc. (Health Net). It is essential that you list the dates, persons and facilities involved, as completely as possible. Please include the original copy of any claims or bills received which are related to your issue. (Be sure to make a copy for your records.) Use reverse side or additional paper if necessary. Mail this form and documents to: Health Net, Appeals and Grievances Department, P.O. Box 10348, Van Nuys, CA 91410-0348 or fax to (877) 831-6019.

Problem Statement: Date of Occurrence: _____Location: _____
Provider Name: _____
Describe the problem/complaint in detail:
_____

_____

_____

_____

_____

Use back of this form if additional space is needed.

Health Net's desire is to provide high quality medical care in the most satisfactory manner possible. To do this, we must be aware of any service difficulties you experience. By filling out this form, you are providing us with necessary information to continually maintain our high standards. We will respond to you in no later than 30 days. If you believe a delay in the decision making may impose an imminent and serious threat to your health, please contact our customer service department at 1-800-522-0088 to request an expedited review.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against t your health plan, you should first telephone your health plan at **1-800-522-0088** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

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