Health Net

Member Grievance/Complaint Form

Date: _____ **Please print all information.**

Complainant information:

Name	( ) Work Phone Number	( ) Home Phone Number	
Address	City	State	Zip Code

Name of person(s) related to complainant:

Name	# ID Number
Name	# ID Number
Name	# ID Number

Nature of complaint: (Check appropriate box(es))

_____ Marketing	_____ Difficulty disenrolling	_____ Member billing
_____ Quality	_____ Transportation	_____ Accessibility to care
_____ Emergency care	_____ Staff attitude	_____ Authorization

Other: _____

_____

Problem statement: Date of Occurrence: _____ Location: _____

Describe the problem/complaint in detail:

_____

_____

_____

_____

Use the back of this form if additional space is needed.

_____ _____

Signature of Member Date
(or signature of parent where member is a minor or incapacitated)

Note: Appropriate action will be initiated to resolve your complaint. You will receive a response within **30 calendar days** from the date of receipt.

If you believe a delay in the decision-making may impose an imminent and serious threat to your health, please contact our Member Services Department toll free at 1-800-675-6110 to request an expedited review.

If you should have any further questions or need additional assistance concerning this matter, please contact our Member Services Department toll free at (800) 675-6110. When complete, please submit this form to: Health Net, Attn: Grievance and Appeals Department B-5, 21281 Burbank Blvd. Woodland Hills, CA 91367. Fax # (818) 676-6182.

The DHCS Medi-Cal Managed Care Ombudsman Program is available to provide assistance in investigating and resolving any grievances you may have about this health plan. If you wish to use the services of the DHCS to help you with your grievance, you may call the Ombudsman Program toll-free at 1-888-452-8609.

At any time during the grievance process, you have the right to request a fair hearing from the California Department of Social Services. You have the right to be represented by legal counsel, a friend, or other spokesperson at the hearing. If you want to request a fair hearing or need assistance obtaining information on legal service organizations for representation, you may call the California Department of Social Services toll-free number at 1-800-952-5253, TDD 1-800-952-8349. You also have the right to request disenrollment from the health plan, through health care options, by calling (800) 430-4263.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (800) 675-6110 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 Website http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Information provided by plan denying coverage to enrollee with terminal illness; Conference to review information

(a) A plan that denies coverage to an enrollee with a terminal illness, which for the purposes of this section refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider, shall provide to the enrollee within five business days all of the following information:

(1) A statement setting forth the specific medical and scientific reasons for denying coverage.

(2) A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.

(3) Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368.

MEDICAL RELEASE

MEMBER: Please provide name and telephone number of any providers who may have treated you for the condition which is the subject of this grievance.

All Medi-cal records obtained will be held in strict confidence and used solely for the purpose of reviewing your grievance.

I HEREBY AUTHORIZE AND REQUEST THE ABOVE LISTED PROVIDER(S) TO RELEASE ANY AND ALL MEDICAL RECORDS TO HEALTH NET SUPPORTING MEDICAL NECESSITY FOR:

_____

Signature: _____ **Date:** _____

(If signed by other than member) RELATIONSHIP: _____
(MOTHER, FATHER, GUARDIAN)