Confidential - Protected Health Information

HEALTH NET ENROLLEE 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. 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 the 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 make every effort to respond within 30 days, whenever possible. 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, TTY: 711 to request an expedited review.

6003757 (8/2013) (9/2019) (3/2022)