



**MEMBER GRIEVANCE/COMPLAINT FORM**

Date: \_\_\_\_\_

**Please print all information.**

**Complainant information:**

\_\_\_\_\_  
Name ( ) Work Telephone Number ( ) Home Telephone 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 all that apply]

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

Other: \_\_\_\_\_

**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.

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

**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 Medical 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 THE SUBJECT OF THIS GRIEVANCE:

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**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

(If signed by other than Member)      **RELATIONSHIP:** \_\_\_\_\_  
(MOTHER, FATHER, GUARDIAN)

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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 or TTY/TDD Number: (800)-431-0964. When complete, please submit this form to: Health Net, Attn: Medi-Cal Member Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348. Fax Number: (877) 831-6019.