Health Net Part D How to
Request an Appeal
(Redetermination)

If you disagree with the coverage determination, you or your appointed representative can ask for an appeal (redetermination). An appeal (redetermination) is a request to re-evaluate our decision not to cover a drug, vaccine, or other Part D benefit. You or your appointed representative may also appeal our decision not to reimburse you for a Part D drug that you paid for.

- You need to file your appeal (redetermination) within 60 calendar days from the date on the notice of our coverage determination (denial letter).
- To file an appeal, you or your physician can print and complete the Part D Appeal & Grievance Form or write a letter stating the nature of the complaint, giving dates, times, persons, places, etc. involved. Please attach copies of any information that may be relevant to the appeal (redetermination). You or your physician may send or fax the appeal to the following address:

Health Net Medicare Appeals & Grievances
P.O. Box 279410
Sacramento, CA 95827
Fax: 1-800-977-6855
TTY/TDD: 1-800-977-6757
Hours of Operation:
8:00 a.m. to 8:00 p.m.
7 days a week

You can name a relative, friend, advocate, or anyone else to represent you in your appeal (redetermination). If you want someone to represent you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. Please complete the Appointment of Representative (AOR) form located on this website and attach this to your appeal or attach a copy of a Durable Power of Attorney or other legal document appointing that person to act as your representative. Please note an AOR is not required when your prescribing physician requests an appeal on your behalf.

- Upon receipt of your appeal (request for redetermination), we will initiate the appeal (redetermination) procedure and promptly acknowledge receipt of your request. We will review your appeal (request for redetermination) and notify you of our decision within 7 calendar days of receiving your appeal.
- If you believe a delay in the decision-making may have an imminent and serious threat to your health, please contact customer service using the toll-free telephone number on your identification card to request an expedited ("fast") appeal (redetermination).
  - Once we receive your expedited ("fast") appeal (redetermination) request, we will contact you within 24 hours of receipt to let you know whether or not the request will be processed as an expedited ("fast") appeal (redetermination).
  - If we process your request as an expedited ("fast") appeal (redetermination), we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to.
  - If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

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Approved 11082011
Appeal (Redetermination) Grievance Form

Health Net Part D How to File a Grievance

A grievance is a term for an expression of dissatisfaction about the plan or the service you have received from the plan.

- If you have a grievance, we encourage you to first call the Customer Service Department at the telephone number on the back of your identification card.
- If we cannot resolve your grievance over the phone, we have a formal procedure to review your grievance.
- To file a grievance in writing, please print and complete the Part D Appeal & Grievance Form or write a letter stating the nature of the complaint, giving dates, times, persons, places, etc. involved. You may send or fax your grievance to the following address:

Health Net Medicare Appeals & Grievances
P.O. Box 279410
Sacramento, CA 95827
Fax: 1-800-977-6855
TTY/TDD: 1-800-977-6757
Hours of Operation:
8:00 a.m. to 8:00 p.m.
7 days a week

- Upon receipt of your complaint, we will initiate the grievance procedure and promptly acknowledge receipt of your request.
- We will notify you of our decision as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your grievance.
- You are entitled to a quick review of your grievance (expedited grievance) if you disagree with our decision in the following circumstances:

  - We deny your request for an expedited (fast) review of a request for drug benefits
  - We deny your request for an expedited (fast) review of an appeal of denied drug benefits

To file an expedited grievance, call or write to:

Health Net Medicare Appeals & Grievances
P.O. Box 279410
Sacramento, CA 95827
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- We will quickly review your request and notify you of our decision within 24 hours of receiving your grievance.

Health Net Part D Member
Appeal & Grievance Form

Please note that completion of this form is not required to file an appeal or grievance. You may write a letter stating the nature of the complaint, giving dates, times, persons, places, etc. involved. Please include copies of any additional information that may be relevant to your complaint or appeal and send or fax to the following address:

Health Net Medicare Appeals & Grievances
P.O. Box 279410
Sacramento, CA 95827
Fax: 1-800-977-6855
TTY/TDD: 1-800-977-6757
Hours of Operation:
8:00 a.m. to 8:00 p.m.
7 days a week

This form is for your use in making suggestions, filing a formal complaint, or appeal regarding any aspect of a Part D drug or service provided to you. Health Net **is required by law** to respond to your complaints or appeals, and a detailed procedure exists for resolving these situations. If you have any questions, please feel free to call the Customer Services department. The customer service contact information may be found on your Health Net identification card.

A Medicare Advantage organization with a Medicare contract. A stand alone prescription drug plan with a Medicare contract.

Please print or type the following information:

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Member Name (Last, first, middle initial)

____________________________________ ____________________________
Address Home Phone number

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City, State, Zip Work Phone number

__________________________________ ________________________________
Name of Employer or Group HNET Member ID number

_______________________________ ___________________
Date of Birth Male/Female

Authorized Representative: If the complaint is filed by someone other than the member, please complete the Appointment of Representative (AOR) form or attach a copy of a Healthcare Durable Power of Attorney or other legal document appointing you to act as the member's representative.

Please state the nature of the complaint, giving dates, times, persons, places, etc. involved. Please attach copies of any additional information that may be relevant to your complaint or appeal.

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Please sign and forward to Health Net at the address or fax number on the previous page.

Date_______________ Signature____

Date_______________ Signature of Representative____