Health Net Appeals and Grievance Dept.
P.O. Box 10450
Van Nuys, CA 91410-0450

Health Net Amber and Health Net Healthy Heart II
Appeals & Grievances Department
REQUEST FOR REDETERMINATION

MEMBER NAME: _____
Member ID Number: _____

A. In your own words, please describe your request for redetermination for reimbursement for a Part D drug you have already purchased. Provide any information you feel may be helpful, including names and dates. Please be sure to include copies of any claim or denial notices, as well as copies of all applicable billing statements, if available.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

B. In your own words, please describe your request for redetermination for authorization for a Part D drug that you have not yet obtained. Provide any information you feel may be helpful, including names and dates. Please be sure to include copies of any denial notices.

_____

_____

Signature: _____ Date: _____