Health Net

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:

SIGNATURE:_____ **DATE:**_ _____

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

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 (TTY:711). 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.