Health Net Access™

MEMBER GRIEVANCE/COMPLAINT FORM

If you do not understand this notice or have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at (888) 788-4408, and someone will assist you. This letter may be available in another language or format. Please call our office for assistance at (888) 788-4408.

Si usted no entiende este aviso o tiene dificultad en leer este aviso porque las letras estan muy pequenas o las palabras estan muy dificil de leer, favor de llamar a nuestra oficina al (888) 788-4408 y alguien le asistira. Si usted desea que un representante le llame y le explique en Español el contenido de esta carta, por favor llame (888) 788-4408.

Date: _____

Your information:

_____

Name | Work or Cell Phone Number | Home Phone Number

_____

Address | City | State | Zip Code

Enrollee information, if you are filing a complaint for another person:

_____

Name | Work or Cell Phone Number | Home Phone Number

_____

Address | City | State | Zip Code

Nature of complaint: (Please check all boxes 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: _____

Please describe the problem in detail: (Please use additional pages, if necessary.)
_____
_____
_____
_____
_____

_____ _____
Signature of enrollee Date
(or signature of parent of minor child, or authorized representative)

If you have any questions or need additional assistance about this matter, please contact our Customer Service Department toll free at (888) 788-4408. Please submit this form to our mailing address at: Health Net Access, Attn: Appeals and Grievances Department, PO Box 9007, Tempe AZ 85281-9707, or it may be hand delivered to 1230 W. Washington St., Suite 401, Tempe AZ 85281. You may also fax this form to (855) 844-0687.

Note: Appropriate action will be initiated to resolve your complaint and you will receive a response within 10 working days from the date of receipt, unless there are extraordinary circumstances. No grievances will take more than 90 calendar days to resolve.

MEDICAL RELEASE

Enrollee: 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 from care providers will be held in strict confidence and used solely for the purpose of reviewing your grievance.

I HEREBY AUTHORIZE AND REQUEST THE 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 the enrollee, please indicate relationship:
_____
(parent, guardian, authorized representative)