Health Net Community Solutions
21281 Burbank Boulevard
Woodland Hills, California 91367-6607
Phone 800.675.6110 Fax 877.831.6019

Mailing Address: Post Office Box 9103
Van Nuys, California 91409-9103

www.healthnet.com

<DATE>

To the Parent(s)/Guardian(s) of <FIRST NAME> <LAST NAME>: **OR** MEMBER NAME
<ADDRESS>
<CITY>, <STATE> <ZIP>

RE: MEMBER NAME

To the Parent(s)/Guardian(s) of <FIRST NAME> <LAST NAME>: **OR** (Dear <TITLE><LAST NAME>:

CHECK member's PREFERRED WRITTEN LANGUAGE in PRIME or Initiating Document. If translation is required then: INSERT PARAGRAPH FROM "TEMPLATE INSERT" IN MEMBER'S LANGUAGE. **OTHERWISE, DELETE IF PREFERRED WRITTEN LANGUAGE IS ENGLISH.**

Health Net's Appeals and Grievances Department is responding to a request made to our Member Services Department on DATE RECEIVED, which indicates your desire to initiate the appeals and grievance process.

<COORDINATOR> will be assembling your file for review and appropriate handling. Health Net is required by state and federal regulations to resolve member appeals and grievance issues within 30 calendar days of receipt. You or your representative may submit additional information for the Plan's review. If You or your representative filed your appeal over the phone, you must also file it in writing. You or your representative may fill out the enclosed Member Grievance/Complaint form and fax to (877) 713-6182 or mail it to the address listed above. You or your representative may submit by fax the additional information to the following fax number (877) 713-6182 or mail it to the address shown above.

Thank you for taking the time to express your concerns. In the future, should you need assistance or information of a general nature, please contact Member Services at (800) 675-6110. Our Telecommunication Device for the Deaf (TDD) may be accessed by calling (800) 880-3165. However, if you need further assistance with this issue, please call <COORDINATOR> directly at (818) 676-<XXXX>.

Sincerely,

<COORDINATOR>

<COORDINATOR>
Appeals & Grievances Case Coordinator
Health Net Community Solutions

Enclosures: Your Rights
Member Grievance/Complaint Form
Notice of Language Assistance (NOLA)
Health Net's Nondiscrimination Notice

If you still do not agree with this decision, you can:

- Ask for an **"Independent Medical Review" (IMR)** and an outside reviewer that is not related to the health plan will review your case
- Ask for a **"State Hearing"** and a judge will review your case

You can ask for both an IMR and State Hearing at the same time. You can also ask for one before the other to see if it will resolve your problem first. For example, if you ask for an IMR first, but do not agree with the decision, you can still ask for a State Hearing later. However, if you ask for a State Hearing first, but the hearing has already taken place, you cannot ask for an IMR. In this case, the State Hearing has the final say.

You will not have to pay for an IMR or State Hearing.

HOW TO REQUEST CONTINUATION OF BENEFITS

If you are currently getting treatment and you want to continue getting treatment, you must ask for an appeal within 10 days from the date of the "Notice of Action" letter or "Notice of Appeal Resolution" letter was postmarked or delivered to you, OR before the date your Physician Group or Health Net says services will stop. You must say that you want to keep getting treatment when you file the appeal. You can ask to continue receiving the Covered Services while the Appeal or State Hearing is pending, if you meet all of the following conditions:

1) Your Appeal is received within **60 days** from the date of the "Notice of Action" letter;
2) You are appealing the termination, suspension, or reduction of previously authorized services;
3) The Covered Services were ordered by an authorized Provider;
4) The period covered by of previously authorized services has not expired; and
5) You submit a request to continue receiving the Covered Services within **10 calendar days** of when the "Notice of Action" letter was sent, or before the intended effective date of the proposed action.

INDEPENDENT MEDICAL REVIEW (IMR)

If you want an IMR, you must ask for one within **180 days** from the date of this "Notice of Appeal Resolution" letter. The paragraph below will provide you with information on how to request an IMR. Note that the term "grievance" is talking about both "complaints" and "appeals."

YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone **Health Net** at **1-800-675-6110** and use **Health Net's appeal** process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Website **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms, and instructions online.

STATE HEARING

If you want a State Hearing, you must ask for one within **120 days** from the date of this "Notice of Appeal Resolution" (NAR) informing you that the previous Adverse Benefit Determination is partially or fully upheld. But, **if you are currently getting treatment and you want to continue getting treatment, you must ask for a State Hearing within 10 days** from the date this letter was postmarked or delivered to you, OR before the date your health plan says services will stop. You must say that you want to keep getting treatment when you ask for the State Hearing.

You can ask for a State Hearing by phone or in writing:

- By phone: Call **1-800-952-5253**. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.

- In writing: Fill out a State Hearing form or send a letter to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

A State Hearing form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 working days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an **"expedited hearing"** and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself. Or, someone a relative, friend, advocate, doctor, or attorney speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an "authorized representative."

LEGAL HELP

You may be able to get free legal help. Call the county's consumer rights hotline. You may also call the local Legal Aid Society in your county at 1-888-804-3536.

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YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE

County	Consumer Rights
Fresno	Fresno Health Consumer Center 2115 Kern Street Suite 1 Fresno, CA 93721 Phone (559) 570 - 1200 Toll Free (800) 675 - 8001 Website http://www.centralcallegal.org
Kern	California Rural Legal Assistance, Inc. 601 High Street (map) Suite C Delano, CA 93215 Phone (661) 725 - 4350 Website http://crla.org Email info@crla.org
Kings	Fresno Health Consumer Center 2115 Kern Street Suite 1 Fresno, CA 93721 Phone (559) 570 - 1200 Toll Free (800) 675 - 8001 Website http://www.centralcallegal.org
Los Angeles	Center for Health Care Rights 520 South Lafayette Park Place Suite 214 Los Angeles, CA 90057 Toll Free (800) 824 - 0780 Email center@healthcarerights.org
Madera	Fresno Health Consumer Center 2115 Kern Street Suite 1 Fresno, CA 93721 Phone (559) 570 - 1200 Toll Free (800) 675 - 8001 Website http://www.centralcallegal.org
Riverside	California Rural Legal Assistance, Inc 1460 6th Street Coachella, CA 92236 Phone (760) 398 - 7261 Website http://crla.org Email info@crla.org

YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE

County	Consumer Rights
Sacramento	Community Legal Services - McGeorge School of Law 3200 Fifth Avenue Sacramento, CA 95818 Phone (916) 340 – 6080
San Bernardino	California Rural Legal Assistance, Inc 1460 6th Street Coachella, CA 92236 Phone (760) 398 - 7261 Website http://crla.org Email info@crla.org
San Diego	California Rural Legal Assistance, Inc. 640 Civic Center Drive #108 Vista, CA 92084 Phone (760) 966 - 0511 Website http://crla.org Email info@crla.org
San Joquin	Legal Services of Northern California Phone: (888) 354-4474
Stanislaus	Central California Legal Services, Inc. Phone: (559) 570-1200
Tulare	Central California Legal Services, Inc. Phone: (559) 570-1200

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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

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 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, Woodland Hills, California 91367. Fax Number: (877) 831-6019.