Health Net of California, Inc.
MA Appeals and Grievances Department
P.O. Box 10450
Van Nuys, CA 91410-0450

Health Net Pearl
Appeals & Grievances Department

REQUEST FOR RECONSIDERATION
(APPEAL)

MEMBER NAME: _____

Reference Number: _____

In your own words, please describe your concerns. Provide any information you feel may be helpful, including names and dates. Please be sure to include copies of any claim or service denial notices, as well as copies of all applicable billing statements, if available.

You request for reconsideration (appeal) must be made within 60 calendar days from the date of Health Net's initial decision. If your request for reconsideration (appeal) is submitted beyond 60 calendar days, please submit an explanation why you were unable to make your request within this timeframe.

Health Net will make its reconsidered determination as expeditiously as your health requires, but no later than 30 calendar days following receipt of your request for reconsideration of a service denial and no later than 60 calendar days following receipt of your request for reconsideration of a claim payment denial.

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Signature: _____ Date: _____

Please return this form to Health Net