Health Net®

Member Complaint Form

For Administrative Use Only
Group Name:
Group No.:
Plan:

Please complete this form and return to:

Member Complaint Dept.
PO Box 3532
Laguna Hills, CA 92654-3532

Member's Name | I.D. No. | Patient's Name

Member's Address

Home Phone ( ) | Work Phone ( )

Provider Name | Provider No. | City

Phone ( ) | Date of Last Appointment

Please give a detailed description of the complaint and include any supporting documentation.

93-3043(3-02)

Underwritten by SafeHealth Life Insurance Company

Signature _____ Date _____