To: Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
Fax: (916) 229-0465
www.healthhelp.ca.gov

Date: ______________________________
Today's Date – Month, Day, Year

RE: REQUEST FOR REVIEW OF CANCELLATION, RESCISSION OR NONRENEWAL OF HEALTH CARE SERVICE PLAN BENEFITS

I request that the Director of the Department of Managed Health Care review the cancellation, rescission or nonrenewal of the plan contract, enrollment, or subscription for health plan benefits pursuant to sections 1365 or 1389.21 of the Knox-Keene Health Care Service Plan Act of 1975, as follows:

1. Name of enrollee, subscriber or group contract holder whose benefits were cancelled, rescinded or not renewed:

____
Full Name – First, Middle and Last Names

2. Name of subscriber, if different than item "1" above:

____
Full Name – First, Middle and Last Names

3. Name of plan:

____

4. Subscriber or Enrollee Account or Identification Number:

____

5. If applicable, the Group Identification Number:

____

6. Date notice of cancellation was received (if known):

Date of Notice: ______________________________
Month, Day, Year

7. Attach copies of:

   (a) The notice of cancellation sent by the plan.

   (b) Any correspondence with the plan regarding the cancellation, rescission or nonrenewal.

   (c) Proof of payment for the last paid coverage period and date of payment.

8. Do you know why the plan cancelled, rescinded or did not renew your coverage? If yes, please explain.

❑ Yes ❑ No

____

____

____

9. State why you believe the cancellation, rescission or nonrenewal is wrong.

____

____

____

____

____

10. Explain why you believe the cause or causes for cancellation described in the notice of cancellation are wrong. Attach copies of any documents that help explain your position.

____

____

____

____

____

____

11. Does the cancellation, rescission or nonrenewal prevent you or any enrollee covered under the policy from receiving medically necessary health care services? If "yes," please explain:

❑ Yes ❑ No

____

____

____

12. Has the person named in item "11" above, whose health care benefits were cancelled, rescinded or not renewed, received any medical or health care since the cancellation, rescission or nonrenewal? If "yes," what services were received and how much did they cost?

❑ Yes ❑ No

____

____

____

Signature of Complainant

____