# Request for Termination Review

westernhealth ADVANTAGE

Today's Date: _____/_____/_____

**Mail to:** Western Health Advantage Member Services
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
**Fax to:** 916.568.0126
**Email to:** memberservices@westernhealth.com; Include in Subject Line: Request for Termination Review
**Questions?** 916.563.2250, 888.563.2250 toll-free or 711 for TTY
OR
**Submit to:** Department of Managed Health Care Help Center
980 9th Street, Suite 500, Sacramento, CA 95814
Fax: (916) 229-0465
learn more: www.healthhelp.ca.gov

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

I request that {someone at WHA and/or] 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. FULL NAME of enrollee, subscriber, or group contract holder whose benefits were cancelled, rescinded, or not renewed:

   First _____ Middle_____Last_____

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

   First _____ Middle_____Last_____

3. PLAN NAME of subscriber or enrollee: _____

4. IDENTIFICATION NUMBER of subscriber or enrollee:_____

5. GROUP IDENTIFICATION NUMBER (if applicable): _____

6. DATE NOTIFICATION OF CANCELLATION WAS RECEIVED (if known): _____/_____/_____

7. ATTACH COPIES of the following:
   (a) The notice of cancellation sent by WHA.
   (b) Any correspondence with WHA 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 Do you know why WHA cancelled, rescinded, or did not renew your coverage? ❍ Yes ❍ No — If yes, please explain:

_____

_____

_____

_____

_____

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

10. Explain why you believe the cause or causes for cancellation described in the notice of cancellation 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? ❍ Yes ❍ No — If yes, please explain:

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 Has the person named in item "11" above, whose health care benefits were cancelled, rescinded or not renewed, received any medical or health care since the cancellation, rescission or nonrenewal?

❍ Yes ❍ No — If yes, what services were received and how much did they cost?

FULL NAME OF COMPLAINANT: _____

SIGNATURE OF COMPLAINANT: _____