

Request for Termination Review



Today's Date: ____/____/____

Mail to: Western Health Advantage Member Services
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833

Secure fax to: 916.568.0126

Secure email via: mywha.org/securemessage

Click on Member Services — Subject Line: Request for Termination Review — Attach this completed form

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 **FULL NAME** of enrollee, subscriber, or group contract holder whose benefits were cancelled, rescinded, or not renewed: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: WESTERN HEALTH ADVANTAGE (WHA)

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 **Do you know why WHA cancelled, rescinded, or did not renew your coverage?** Yes No — If yes, please explain: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 Has the person named in item "11" above, whose health care benefits were cancelled, rescinded or not renewed, received any medical or health care since the cancellation, rescission or nonrenewal?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: _____