LIBERTY DENTAL PLAN

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

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

RE: Request for Review of Cancellation, Rescission, or Nonrenewal of Health Care Service Plan Benefits

583 **CALIFORNIA CODE OF REGULATIONS** **§ 1300.65.1**

I request that the Director of the Department of Managed Health Care review the cancellation, rescission, 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 Name of enrollee, subscriber, or group contract holder whose benefits were cancelled, rescinded, or not renewed:		
First Name:	Middle Name:	Last Name:
2. Name of enrollee, subscriber, or group contract holder whose benefits were cancelled, rescinded, or not renewed:		
First Name:	Middle Name:	Last Name:
3. Name of subscriber, if different than "1" above:		
First Name:	Middle Name:	Last Name:

4. Name of Plan:	**5. Subscriber or Enrollee Account or Identification Number:**
Plan:	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 Do you know why the plan cancelled, rescinded, or did not renew your coverage?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 that 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 Has the person named in item "11" above, whose health care benefits were cancelled, rescinded, or not renewed, received any medical or health care since the cancellation, rescission, or nonrenewal?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:	**X**

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1365, Health and Safety Code.