Grievance Form

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by Health Net Federal Services, LLC (HNFS) on behalf of the TRICARE® program, and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199, and E.O.9397 (SSN), as amended.

PURPOSE: To collect information from you in order to process the grievance, respond to the requestor and/or take action to correct deficiencies.

ROUTINE USES: Your information may be disclosed in order to investigate waste, fraud and abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/privacy/SORNs and as permitted by ther Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), and includes purposes of treatment, payment, and health care operations.

DISCLOSURE: Voluntary; if you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process an individual's request.

For grievances regarding a provider or services by Health Net Federal Services, LLC (Health Net), return form to: Health Net Federal Services, LLC Attn: Grievances PO Box 8128 Virginia Beach, VA 23450-8128 Fax: 1-844-802-2531	**For claims related issues DO NOT USE this form. Contact PGBA at the following:** Phone: 1-844-866-WEST (9378) Online: http://www.tricare-west.com Mail: PGBA – Claims Correspondence PO Box 202100 Florence, SC 29502-2100

Name of involved beneficiary:	**Date of birth:**	**Sponsor SSN:**	**Beneficiary DBN:**

*** Your name:**	**Relationship to the beneficiary:**	**Daytime phone number:**	
Mailing address:	**City:**	**State:**	**ZIP code:**

** If you are not the involved beneficiary and the beneficiary is age 18 or older, the adult beneficiary may complete an Authorization to Disclose Information form (available on http://www.tricare-west.com) so we may respond directly to you. If we do not have an Authorization to Disclose Information form on file we must respond directly to the adult beneficiary.*

Name of provider, HNFS associate or department of concern:		**Provider mailing address:**		
Date(s) of incident(s):	**Provider phone number:**	**City:**	**State:**	**ZIP code:**

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Describe concern(s): Please include what happened, when it happened and where it happened. Be specific about any statements made to you including the names of individuals who made the statements. Try to describe the events in the order in which they happened. You may attach additional pages or supporting documentation.	
Signature:	**Date:**

Health Net Federal Services, LLC, TRICARE Grievances • PO Box 8128 • Virginia Beach, VA 23450-8128 • www.tricare-west.com • 1-844-866-WEST (9378)

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