HealthNet Compliance Dispute Claim Form

The undersigned hereby declares that he or she is a Class Member who did not Opt-Out of the settlement Agreement.

Name of Class Member (Physician)

Address

City, State, and Zip Code

Physician's Name (print)

____

Physician's Signature

____

Tax Identification Number under which covered physician services were provided, if applicable

Physician's Telephone Number

E-mail address

Check one of the following:

___ I am bringing this Compliance Dispute on my own behalf.

___ I hereby authorize the following Signatory Medical Society to bring this Compliance Dispute on my behalf:____

Please set forth in detail below, using particularized facts, Company's conduct which you allege constitutes a material breach of Company's Obligations under - 7 of the settlement Agreement. Please note the specific provision of - 7 allegedly breached, and please describe how the undersigned has been harmed by the alleged breach. Please also set forth the relief that you request. Upon receipt of this electronic submission, we will contact you regarding supporting documentation.

Please fax this form to:
(203) 821-2009

Or

Mail to:
195 Church Street
13th Floor
New Haven, CT 06510-2009