



Provider Complaint and Dispute Request(s)

IMPORTANT: To obtain a review submit this form as well as information that will support your complaint or appeal. This may include, but is not limited to, medical and dental records, chart and progress notes, signed and dated financial documents, any other relevant documentation. Please submit your request and all the required documentation to the address listed on the Explanation of Payment (EOP) or other correspondence received from LIBERTY Dental Plan (LIBERTY). Please note that pre-service disputes do not require this form and follow the enrollee appeal process; see "Filing on Behalf of an Enrollee."

Please provide the following information:

Today's Date:	Member's ID No.:	Member's Group No.:	Member's Group Name:
Member's First Name:		Member's Last Name:	Member's Date of Birth:
Provider's First Name:		Provider's Last Name:	Provider NPI/API:
Office ID No.(LIBERTY assigned):	Office Name:		LIBERTY Contracted (Y/N):
Contact's Name and Title:		Contact's Phone No.:	Contact's Fax No.:
Contact's Full Address (where complaint/dispute resolution letter should be sent)			Contact's Email Address:

To ensure LIBERTY can appropriately review and respond to your request, please provide the following information. You may use this form to appeal multiple dates of services for the same member.

Claim Number(s):	Service Date(s):
Reference No./Authorization No. (if applicable):	Initial Denial Notification Date(s):
Service(s) Being Disputed:	
Summary of Complaint/Dispute:	
How can LIBERTY fairly resolve your issue?	

Missing Information:

Submitted requests that are missing the required information, as detailed above, will be returned. To ensure timely processing of your request, please provide all required information and supporting documentation.

Timely Filing:

Complaints and disputes submitted after federal and state filing timeframes will be dismissed, unless good cause for the late filing has been established.

Filing on Behalf of an Enrollee:

Appeals submitted on behalf of an enrollee that are associated with medical necessity, out-of-network services benefit denials, or services for which the enrollee can be held financially liable, must be accompanied by an Appointment of Representative Form or other office documentation signed and dated by the enrollee you are appealing on behalf of, unless you are an attorney, power of attorney, court appointment guardian or health care proxy agent with associated documentation.

Verbal Submissions:

Medicaid providers in Florida and Nevada may request a claims payment dispute over the telephone. However, all required information outlined on this form is still needed for proper processing.

Documentation Required:

All Medical and/or Dental Information Needed to Determine Medical/Dental Necessity.

Examples:

- Radiology: Radiographs, Intra-oral Photographs, Reports, Referring MS Script (**faxed radiographs not accepted**)
- Consultations: Consultation Reports, Progress Notes, Lab Reports
- Procedures: Progress Notes, Procedure Reports, Supporting Consultation Reports, PCP Progress Notes
- Timely Filing: Billing Notes, Fax Confirmation, Web Portal Confirmation Certified and Signed Mail Care

Attn: Grievance & Appeals

LIBERTY Dental Plan
 PO Box 26110
 Santa Ana, CA 92799-6110
 Fax: (833) 250-1814
 Email: ganda@libertydentalplan.com

***Submission of this form constitutes agreement not to bill the patient during the dispute resolution process.**