Provider Complaint Form

LIBERTY DENTAL PLAN
Making members shine, one smile at a time™

Office/Provider Information	Patient/Member Information
Name:	**Name:**
Address:	**Address:**
Contact Person:	**ID No.:**
Phone:	**DOB:**
Fax:	**Phone:**

Select Reason for Your Complaint			
☐	**Plan Administration**	☐	**Provider Reimbursement**
☐	**Health Care Delivery**	☐	**Contracting**
☐	**Other**		

Fill out the form completely and make sure you keep a copy for your records. Send this form and **all the necessary medical and/or dental documentation** to support your complaint to the following:

LIBERTY Dental Plan, Attn: Grievances and Appeals, P.O. Box 15149, Tampa, FL 33684, or you can fax us at: **1-833-250-1816** or **email** us at: **FLGandA@libertydentalplan.com**

Explanation of Your Issue(s):

Your complaint will be processed once all necessary documentation is received. You will receive an acknowledgement letter within 3 business days of the receipt of your complaint by the Plan. You will receive a response letter to your complaint within 30 calendar days.

Failure to submit all supporting documentation may delay our response to your complaint. If your complaint includes multiple members/patients, list them all separately.

Contact your LIBERTY Network Manager for questions or concerns by calling us at 1-888-352-7924.