



NEVADA MEDICAID MEMBER GRIEVANCE AND APPEAL FORM

Your concerns are important to Liberty Dental Plan (Liberty). If you do not agree with the decision we made about your dental care or services, you can ask for an appeal. If you are unhappy with your dental provider, the care you received, how you were treated, or Liberty, you can file a grievance (complaint).

You can file a grievance or appeal with Liberty:

- Fill out this form and:
 - Mail it to us at: Attn: **Grievances/Appeals P.O. Box 401086, Las Vegas, NV 89140**
 - Email: **GandA@libertydentalplan.com**
 - Fax it to us at: **1-833-250-1814**
- Go online at:
 - <http://www.libertydentalplan.com/NV-Medicaid-Check-Up/File-a-Grievance.aspx?state=NV>
- Call us at:
 - Member Services
 - **1-866-609-0418**
 - TTY: **1-877-855-8039**
- In Person at:
 - **6385 S. Rainbow Blvd., Suite 200, Las Vegas, NV 89118**

Important Information

- For more details on grievance and appeal deadlines, please see your Member Handbook.
- You can have someone file a grievance or appeal for you. You must give them your written approval to allow this.
- We will let you know in writing after we get your grievance or appeal.
- We will also let you know in writing about our decision.
- A fast (expedited) review is available if waiting could harm your health or dental condition.
- You can ask for more time to send us information. We may also request more time if it helps you.
- If you need an interpreter, let us know. Interpreters are free.
- You or someone you approve of can add information to your case at any time.
- You or someone you approve can ask for a free copy of your file at any time, including the information we used to make the decision.

The letters we send (acknowledgement and response) will include the name and phone number of the person at Liberty handling your case. You can contact this person at any time to ask questions or to add information to your case.

The person handling your case can also request more information to help resolve your case. This may include contacting your dental provider for records or a written response to your concerns.



NEVADA MEDICAID MEMBER GRIEVANCE AND APPEAL FORM

PART 1: MEMBER INFORMATION (PLEASE PRINT)

<i>First and Last Name</i>	<i>Today's Date</i>
<i>Member Identification Number</i>	<i>Date of Birth</i>
<i>Daytime Phone Number</i>	<i>Evening Phone Number</i>
<i>Preferred Method of Contact</i> <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail	<i>Email Address</i>
<i>Best Time to Contact</i> _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<i>Name and Relation of Person Filing Grievance/Appeal</i> <i>(if other than the member)</i>
<i>Full Mailing Address</i>	

PART 2: DENTAL OFFICE/PROVIDER INFORMATION (PLEASE PRINT)

I am authorizing Liberty to request my information from the following office:

<i>Dental Office, Provider, or Staff Member Name</i>	<i>Phone Number</i>
<i>Full Street Address</i>	

PART 3: SUMMARY OF GRIEVANCE OR APPEAL

Please give us as many details as you can, including dates, names, and any treatment. Include copies of bills, checks, or other information about your concerns.

Member Signature

Date

*Encl: Notice of Availability
Non-Discrimination Notice*