

DENTA	L PLAN	WRIT	TEN MEM	BER GR	IEVANCE FORM	
MEMBER INFO						
Member last name		Member first name	nber first name		Today's date	
Member street address		City		State	ZIP code	
Member phone number		Member identification number (see i	Member identification number (see identification card)			
Employer or Group		Patient name	Patient name Relation		nship	
DENTAL OFFICE	/PROVIDER INFORMATION					
	BERTY Dental Plan to request my information,	including chart records and x-rays, if appli	cable, from the follo	wing office:		
Office number	Dental office name				Date of last visit	
Dental office street	address	City		State	ZIP Code	
Dental office phone number		Name(s) of dental office staff involve	Name(s) of dental office staff involved (if known)			
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Description of C	ance in detail. Please provide the dates, name	or and treatment that are the cubiect of w	our griovanco. Attac	h additional	nages if necessary	
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Description of Grievance					
Describe your grievance in detail. Please provide	e the dates, names and treatment that are the subject of your grievance. Attach additional pages, if necessary.				
What is your desired resolution to your concern(	s)?				
MEMBERS OF LIBERTY DENTAL PLAN ONLY - PLEASE SEND COMPLETED FORM TO:					
LIBERTY Dental Plan	Or you may submit your grievance:				
Attention: Quality Management Department	By fax to LIBERTY's Member Services Department fax at (949) 223-0011, or				
P.O. Box 26110	Verbally by calling LIBERTY Dental Plan's Member Services Department at toll-free number: (888) 703-6999, or				
Santa Ana, CA 92799-6110	By using our website online grievance filing process by visiting <u>www.libertydentalplan.com</u> .				

## IF YOUR HEALTH PLAN CONTRACTS WITH LIBERTY TO PROVIDE YOUR DENTAL BENEFITS:

You will receive a letter acknowledging receipt of your grievance within five (5) calendar days of receipt by LIBERTY. You will receive a written resolution to your grievance within thirty (30) calendar days of receipt by LIBERTY.

You should contact your Health Plan for information on how to submit a grievance or appeal, or you may contact LIBERTY Dental Plan.

- When contacting LIBERTY to inquire on how to submit a grievance or appeal, please call (888) 703-6999.
- If your Health Plan allows, LIBERTY may accept your grievance or appeal verbally.
- If your Health Plan allows, LIBERTY may accept this completed form as your written grievance or appeal.
- A LIBERTY Member Services Representative will let you know if your Health Plan requires that you contact them directly to file a grievance or appeal regarding your dental treatment and/or services.

Document1 pg. 2