Dental Grievance Form
Formulario de Quejas

Please complete and return this form to the mailing address shown below at your earliest convenience. Receipt from you will be acknowledged within 5 calendar days, and you will be notified of the resolution within 30 calendar days. Thank you for your cooperation.

Por favor llene y regrese este Formulario lo más pronto posible a la dirección que aparece abajo. Le avisaremos en cinco días del dia que recibimos su formulario, y le haremos saber la resolución en 30 días. Gracias por su cooperación.

MEMBER INFORMATION
INFORMACIÓN DEL MIEMBRO

Member Name
Nombre del Miembro

Identification #
 # de Identificación

Patient Name (if applicable)
Nombre del Paciente (si es aplicable)

Member Address
Dirección del Miembro

Apt #
 # de Apt

City
Ciudad

State
Estado

Zip Code
Código Postal

Day Phone #
Telefono de Día

Evening Phone #
Telefono de Noche

Email Address
Dirección del Email

PROVIDER INFORMATION
INFORMACIÓN DEL DENTISTA

Provider Name
Nombre del Dentista

Provider Address
Dirección del Dentista

City
Ciudad

State
Estado

Zip Code
Código Postal

Date of First Visit
Fecha de la Primera Visita

Date Problem Occurred
Fecha en que Ocurrió el Problema

DESCRIBE YOUR GRIEVANCE (PROBLEM)
DESCRIBA SU QUEJA (PROBLEMA)

Please attach additional sheet if necessary
Por favor agregue una hoja adicional si es necesario

If you talked with the Provider office and/or plan personnel about this matter, please list their name(s)
Si usted habló con el dentista y/o con el personal del plan acerca de este asunto, por favor escriba sus nombres aqui

I hereby certify that this information is true and correct to the best of my knowledge
Yo certifico que esta información es verdadera y correcta según mi leal saber y entender

X _____

Member Signature
Firma del Miembro

Date
Fecha

Mailing Address: Grievances and Appeals, P.O. Box 30569, Salt Lake City, UT 84130-0569

Phone: 1-800-445-9090

PDVCA1283-001

EXPEDITED REVIEW

The Plan makes every effort to process your appeal as quickly as possible. In some cases, you have a right to an expedited 72- hour appeal if your health or ability to function could be seriously harmed by waiting for a standard appeal, which may take up to 30 days. You may file an oral or written request for a 72-hour appeal. Call, write or fax the Plan. Ask for an "expedited review," a "72-hour review," or say, "I believe my health could be seriously harmed by waiting for a standard review."

Call:

1-800-445-9090 (5 a.m. – 8 p.m. Pacific)
TTY 711

Write:

Grievances and Appeals
P.O. Box 30569
Salt Lake City, UT 84130-0569

Or Fax:
(714) 364-6266.

FOR ALL CALIFORNIA MEMBERS

If a complaint has been sent for immediate expedited review, the Plan will immediately inform you in writing of your right to notify the Department of Managed Health Care of the grievance. The Plan will provide you and the Department of Managed Health Care with a written statement of the disposition of pending status of the expedited review no later than three days from receipt of the complaint.

The following language is required by the Department of Managed Health Care:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-445-9090** or **TTY 711** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR. If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online."