



MEMBER GRIEVANCE AND APPEAL FORM

Your concerns are important to LIBERTY Dental Plan (LIBERTY). If you disagree with our decision on your requested or completed services, you can ask for an appeal. If you are not happy with your dental provider, services, or how you were treated, you can ask for 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 15149, Tampa, FL 33684**
 - Fax it to us at: **1-833-250-1814**
- Go online at:
 - <https://www.libertydentalplan.com/Members/File-a-Grievance-or-Appeal.aspx>
- Call:
 - Member Services
 - **1-833-276-0850**
 - TTY: **1-877-855-8039**

Important Information

- Please see your Member Handbook or Evidence of Coverage for more details on the filing limits for grievances and appeals.
- You can have someone ask for a grievance or appeal for you. We must have your written approval to let someone ask for a grievance or appeal for you.
- We will mail you a letter acknowledging receipt of your grievance/appeal.
- We will mail you a letter with our response to your grievance/appeal.
- Urgent (expedited) review is available for cases that involve serious threat to your dental health.
- You can ask for an additional time on your case, or we can ask for additional time if it is in your best interest.
- We will give you an interpreter at not cost.
- You or someone you authorization have the right to review your case file at any time.
- We will give you copies of your records at no cost.
- Please call our Member Services at the numbers listed above, if you need help filling out this form.

The acknowledgement and response letters will have the name and phone number of the person who is handling your case. You can call the that person to ask questions or add details to your case at any time.



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The person handling your case will try to get more information to help resolved your case, including asking the dental office for records or a written response to your concerns.

PART 1: ENROLLEE INFORMATION (PLEASE PRINT)	
<i>First and Last Name</i>	<i>Today's date</i>
<i>Enrollee 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 (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>	



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PART 3: SUMMARY OF GRIEVANCE OR APPEAL

Please give us as many details as you can, if possible please provide the dates, names and any treatment. Include copies for all bills, checks, or other information related to your concerns.

Enrollee Signature

Date

*Encl: Notice of Language Assistance
Non-Discrimination Notice
State Regulatory Language*