LIBERTY DENTAL PLAN

WRITTEN MEMBER GRIEVANCE FORM - NEVADA

MEMBER INFORMATION

Member last name	*Member first name*	*Today's date*	
Member street address	*City*	*State*	*ZIP code*
Member phone number	*Member identification number (see identification card)*		
Employer or Group	*Patient name*	*Relationship*	

DENTAL OFFICE/PROVIDER INFORMATION

I am authorizing LIBERTY Dental Plan to request my information, including chart records and x-rays, if applicable, from the following 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 involved (if known)*		

Description of Grievance

Describe your grievance in detail. Please provide the dates, names and treatment that are the subject of your grievance. Attach additional pages, if necessary.

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What is your desired resolution to your concern(s)?

PLEASE SEND COMPLETED FORM TO:	
LIBERTY Dental Plan Attention: Quality Management Department P.O. Box 26110 Santa Ana, CA 92799-6110	**Or you may submit your grievance:** • By fax to LIBERTY's Quality Management Department fax at **(949) 270-0109**, or • Verbally by calling LIBERTY Dental Plan's Member Services Department at toll-free number: **(888) 703-6999**, or • By using our website online grievance filing process by visiting **www.libertydentalplan.com**.
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.**	

If you have a grievance against your Health Plan, you should first telephone your Health Plan at **1-888-401-1128** and use your Health Plan's grievance process before contacting the Commissioner, Division of Insurance. 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 remained unresolved for more than 30 days, you may call the Division of Insurance for assistance. You may also be eligible for 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 Division of Insurance has a telephone number for the Carson City office (**1-775-687-4270**) as well as the Las Vegas office (**1-702-486-4009**), and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. You may also visit the Division of Insurance's Internet web site **http://www.doi.state.nv.us** for complaint forms, IMR application forms and instructions online.

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-703-6999.

Spanish (Español)

IMPORTANTE: ¿Puede leer esta noticia? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta noticia escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-888-703-6999.