



# WRITTEN MEMBER GRIEVANCE FORM – FLORIDA

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			
<b>I am authorizing LIBERTY Dental Plan to request my information, including chart records and x-rays, if applicable, from the following office:</b>			
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
<p>Describe your grievance in detail. Please provide the dates, names and treatment that are the subject of your grievance. Attach additional pages, if necessary.</p>

## 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.

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](http://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 are not satisfied with LIBERTY's final decision, you may contact the Florida Department of Financial Services (FDFS) in writing within 365 days of receipt of the final decision letter. You also have the right to contact FDFS at any time to inform them of an unresolved grievance.

### ***The Florida Department of Financial Services***

*Consumer Complaints Division*

*State Capitol Larson Building*

*200 East Gaines Street, Room 637*

*Tallahassee, Florida 32399-0300*

***Telephone 1-800-342-2762***

**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.