

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.

[Empty space for describing the grievance]

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

[Empty space for desired resolution]

MEMBERS OF LIBERTY DENTAL PLAN ONLY - 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 Member Services Department fax at **(949) 223-0011**, 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 YOUR HEALTH PLAN CONTRACTS WITH LIBERTY TO PROVIDE YOUR DENTAL BENEFITS:

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.