LIBERTY DENTAL PLAN

WRITTEN MEMBER GRIEVANCE AND APPEAL FORM – CALIFORNIA

Please use this form to help file a grievance or appeal with LIBERTY Dental Plan (LIBERTY). You can also use this form to give LIBERTY more information to help us review your case. If you have filed an **appeal over the telephone**, you can complete this form and mail it back to LIBERTY. This is optional. We will review your case without a written appeal.

MEMBER INFORMATION (PLEASE PRINT)			
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*	

AUTHORIZED REPRESENTATIVE INFORMATION, IF APPLICABLE (PLEASE PRINT)		
I am authorizing LIBERTY Dental Plan to allow the following person to act on my behalf during the grievance/appeals		
Representative last name	*Representative first name*	*Representative phone number*
Representative Signature	*Member Signature*	

DENTAL OFFICE/PROVIDER INFORMATION (PLEASE PRINT)			
I am authorizing LIBERTY Dental Plan to request my information, including chart records and x-rays, if applicable, from			
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)*		

***Medicaid Appeals** must be filed within 60 days from the date on your Denial Letter.*

***Medicaid Grievances** can be filed at any time.*

***Medicare Appeals and Grievances** must be filed within 90 days from the date on your Denial Letter or from the event that causes your dissatisfaction*

***Commercial/Individual Appeals and Grievances** much be filed within 180 days from the date on your Denial Letter or from the event that causes your dissatisfaction*

If you need help completing this form, call our Member Services Department at **888-703-6999** or TTY **877-855-8039,** Monday through Friday 8:00 a.m. to 5:00 p.m. We can give you an interpreter at no cost, if you need one. You or someone you authorize have the right to review your case file at any time. We'll give you copies free of charge.

SUMMARY OF GRIEVANCE OR APPEAL
Please share any information you have about your grievance or appeal. Please give us as many details as you can, if possible please provide the dates, names and any treatment. If needed you can attach an additional page.
Please share with us how you would like to see your grievance or appeal resolved.

Member Signature **Date**

PLEASE SEND COMPLETED SIGNED FORM TO:	
Mail To: **LIBERTY Dental Plan of California** **Grievances and Appeals Department** **P.O. Box 26110** **Santa Ana, CA 92602-26110**	• Fax to LIBERTY's Grievances and Appeals Department fax at **949-270-0109** • Telephone LIBERTY Dental Plan's Member Services Department at **866-703-6999**, or TTY **(877) 855-8039** • Electronically using the website online grievance filing process by visiting **www.libertydentalplan.com**. • Emailing us at: **GandA@libertydentalplan.com**
You will receive a letter acknowledging receipt of your grievance or appeal within 5 calendar days of receipt by LIBERTY. **You will receive a written resolution to your grievance or appeal within 30 calendar days of receipt by LIBERTY.**	

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 **1-888-703-6999** 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 remained unresolved for more than 30 days, you may call the Department 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 Department also has a toll-free telephone number **(1-888-HMO-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms, and instructions online.

IMPORTANT: You can get an interpreter at no cost to talk to your dentist or dental plan. To get an interpreter or to request written information (in your language or in a different format, such as Braille or larger font), first call your Dental plan's phone number at 1-888-703-6999. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1-888-466-2219.

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un intérprete o pedir información escrita (en su idioma o en algún formato diferente, como Braille o tipo de letra más grande), primero llame al número de teléfono de su plan de salud al 1-888-703-6999. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de ayuda de HMO al 1-888-466-2219. (Spanish)

重要提示：您與您的醫生或保健計劃工作人員交談時，可獲得免費口譯服務。如需口譯員服務或索取（用給您的語言或布萊葉盲文或大字體等不同格式提供的）書面資料，請先打電話給您的保健計劃，電話號碼 1-888-703-6999。會講（您的語言）的人士將為您提供協助。如需更多協助，請打電話給 HMO 協助中心，電話號碼 1-888-466-2219。(Cantonese or Mandarin)

هام: يمكنك الحصول على خدمات مترجم فوري مجاناً للتحدث مع طبيبك أو خطتك الصحية. للحصول على مترجم فوري أو لطلب معلومات مكتوبة (بلغتك أو بصيغة أخرى، مثل طريقة برايل أو بخط كبير)، اتصل أولاً برقم هاتف الخطة الصحية على 1-888-703-6999. سيساعدك شخص ما يتحدث (نفس لغتك). إذا كنت تريد المزيد من المساعدة، اتصل بمركز مساعدة HMO على الرقم 1-888-466-2219. (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿՈՒԹՅՈՒՆ. Դուք կարող եք խոսել Ձեր բժշկի կամ առողջապահական ծրագրի հետ՝ օգտվելով թարգմանչի ծառայություններից առանց որևէ վճարի: Թարգմանիչ ունենալու կամ գրավոր տեղեկություն խնդրելու համար (հայերենով կամ մեկ այլ ձևաչափով, օրինակ՝ Բրայլը կամ մեծ տառաչափը), նախ զանգահարեք առողջապահական ծրագրի հեռախոսահամարով՝ 1-888-703-6999: Ցանկացած մեկը, ով խոսում է հայերեն, կարող է օգնել Ձեզ: Եթե Ձեզ լրացուցիչ օգնություն է անհրաժեշտ, ապա զանգահարեք Առողջապահական օժանդակության կազմակերպության (HMO) Օգնության կենտրոն՝ 1-888-466-2219 հեռախոսահամարով: (Armenian)

សារ:សំខាន់: អ្នកអាចទទួលអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃ ដើម្បីនិយាយទៅកាន់វេជ្ជបណ្ឌិត ឬគំរោងសុខភាពរបស់អ្នក។ ដើម្បីទទួលអ្នកបកប្រែផ្ទាល់មាត់ ឬស្នើសុំព័ត៌មានជាលាយលក្ខណ៍អក្សរ (ជាភាសាខ្មែរ ឬជាទំរង់ផ្សេងទៀត ដូចជាអក្សរប្រ៊ីលី ឬអក្សរពុម្ពធំ។) សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក តាមលេខ 1-888-703-6999 ជាមុនសិន។ អ្នកនិយាយភាសាខ្មែរ អាចជួយអ្នកបាន។ បើសិនអ្នកត្រូវការជំនួយបន្ថែម សូមទូរស័ព្ទទៅមជ្ឈមណ្ឌលជំនួយអង្គការថែរក្សាសុខភាព HMO តាមលេខ 1-888-466-2219។ (Khmer)

مهم: برای گفتگو با پزشک معالج یا طرح بیمه می توانید بطور رایگان مترجم حضوری داشته باشید. برای درخواست مترجم حضوری یا برای دریافت اطلاعات بصورت کتبی (به زبان خود، یا با فرمت های دیگر مانند بریل یا چاپ درشت) ابتدا با شماره تلفن طرح خود یعنی 1-888-703-6999 تماس حاصل نمایید. فردی که (زبان شما را) صحبت می کند، می تواند شما را یاری دهد. اگر به کمک بیشتر نیاز دارید با مرکز کمک رسانی اچ ام او (HMO) به شماره 1-888-466-2219 تماس حاصل نمایید. (Farsi)

TSEEM CEEB: Muaj tus neeg txhais lus pub dawb rau koj kom koj tham tau nrog koj tus kws kho mob los yog nrog lub chaw pab them nqi kho mob rau koj. Yog xav tau ib tug neeg txhais lus los yog xav tau cov ntaub ntawv (sau ua koj yam lus los sis ua lwm yam ntawv, zoo li ua lus Braille los sis ua ntawv loj loj), xub hu rau koj lub chaw pab them nqi kho mob tus xov tooj ntawm 1-888-703-6999. Yuav muaj ib tug neeg hais lus Hmoob pab tau koj. Yog koj xav tau kev pab ntxiv, hu rau HMO Qhov Chaw Txais Tos Pab Neeg ntawm 1-888-466-2219. (Hmong)

중요: 의사나 건강 플랜과 대화하실 때 무료 통역 서비스를 받으실 수 있습니다. 통역을 구하시거나 문자 정보(한국어 번역본 또는 점자나 큰 글자 같이 다른 형식으로 된 정보)를 요청하시려면, 가입하신 건강 플랜에 1-888-703-6999로 먼저 전화하십시오. 한국어를 하는 사람이 도와드릴 수 있습니다. 도움이 더 필요하시면 HMO 도움 센터에 1-888-466-2219로 연락하십시오. (Korean)

ВАЖНО: Вы можете бесплатно воспользоваться услугами переводчика во время обращения к врачу или в страховой план. Чтобы запросить услуги переводчика или письменную информацию (на русском языке или в другом формате, например, шрифтом Брайля или крупным шрифтом), позвоните в свой страховой план по телефону 1-888-703-6999. Вам окажет помощь русскоговорящий сотрудник. Если вам нужна помощь в других вопросах, позвоните в справочный центр Организации медицинского обеспечения (HMO) по телефону 1-888-466-2219. (Russian)

MAHALAGA: Maaari kang kumuha ng isang tagasalin nang walang bayad upang makipag-usap sa iyong doktor o planong pangkalusugan. Upang makakuha ng isang tagasalin o upang humiling ng nakasulat na impormasyon (sa iyong wika o sa ibang anyo, tulad ng Braille o malalaking letra), tawagan muna ang numero ng telepono ng iyong planong pangkalusugan sa 1-888-703-6999. Ang isang tao na nakapagsasalita ng Tagalog ay maaaring tumulong sa iyo. Kung kailangan mo ng karagdagang tulong, tawagan ang Sentro ng Pagtulong ng HMO sa 1-888-466-2219. (Tagalog)

LƯU Ý QUAN TRỌNG: Quý vị có thể được cấp dịch vụ thông dịch miễn phí khi đi khám tại văn phòng bác sĩ hoặc khi cần liên lạc với chương trình bảo hiểm sức khỏe của quý vị. Để được cấp dịch vụ thông dịch hoặc yêu cầu văn bản thông tin bằng tiếng Việt hoặc bằng một hình thức khác như chữ nổi hoặc bản in bằng chữ khổ lớn, trước tiên hãy gọi số điện thoại của chương trình bảo hiểm sức khỏe của quý vị tại 1-888-703-6999. Sẽ có người nói tiếng Việt giúp đỡ quý vị. Nếu quý vị cần được giúp đỡ thêm, vui lòng gọi Trung tâm Hỗ trợ HMO theo số 1-888-466-2219. (Vietnamese)

ਮਹੱਤਵਪੂਰਨ: ਤੁਸੀਂ ਆਪਣੇ ਡਾਕਟਰ ਜਾਂ ਸਿਹਤ ਯੋਜਨਾ ਲਈ ਗੱਲ ਕਰਨ ਵਾਸਤੇ ਮੁਫਤ ਅਨੁਵਾਦਕ ਪਾ ਸਕਦੇ ਹੋ| ਅਨੁਵਾਦਕ ਪਾਉਣ ਲਈ ਜਾਂ ਲਿਖਤੀ ਜਾਣਕਾਰੀ (ਆਪਣੀ ਭਾਸ਼ਾ ਜਾਂ ਵੱਖਰੇ ਫਾਰਮੈਟ ਵਿੱਚ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਜਾਂ ਵੱਡੇ ਅੱਖਰ) ਦੀ ਬੇਨਤੀ ਕਰਨ ਲਈ, ਪਹਿਲਾਂ 1-888-703-6999 'ਤੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਦੇ ਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ| ਜੋ ਵੀ (ਤੁਹਾਡੀ ਭਾਸ਼ਾ) ਬੋਲੇਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰ ਸਕਦਾ ਹੈ| ਜੇਕਰ ਤੁਹਾਨੂੰ ਹੋਰ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-888-466-2219 'ਤੇ HMO Help Center (ਐਚ.ਐਮ.ਓ. ਸਹਾਇਤਾ ਸੈਂਟਰ) ਨੂੰ ਕਾਲ ਕਰੋ| (Punjabi)

重要 通訳を通して医師や医療保険会社とお話しいただけます。料金はかかりません。日本語でサポートを受けたり、日本語で書かれた情報を入手するには、あなたの医療保険会社（1-888-703-6999）までお電話ください。日本語が話せるスタッフがお手伝いします。さらなるサポートが必要な場合は、HMO Help Center（1-888-466-2219）までお電話ください。(Japanese)

ສຳຄັນ: ເຈົ້າສາມາດມີນາຍພາສາໂດຍບໍ່ຕ້ອງເສຍຄ່າເພື່ອເວົ້ານຳໝໍ່ເດີ ຫຼື ແຜນທັນຕະແພດຂອງເຈົ້າ. ເພື່ອໄດ້ນາຍພາສາ ຫຼື ຂໍ້ມູນທີ່ເປັນລາຍລັກອັກສອນ (ເປັນພາສາຂອງເຈົ້າ ຫຼື ຮູບແບບອື່ນ, ເຊັ່ນ ພາສານູນ (Braille) ຫຼື ຕົວຫນັງສືທີ່ໃຫຍ່ກວ່າ), ໂທລະສັບໄປຫາແຜນທັນຕະແພດຂອງເຈົ້າກ່ອນ ຕາມໝາຍເລກໂທລະສັບ 1-888-703-6999. ຜູ້ທີ່ເວົ້າພາສາ (ລາວ)

ສາມາດຊ່ວຍເຫລືອເຈົ້າໄດ້. ຖ້າວ່າເຈົ້າຕ້ອງການຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ, ໂທລະສັບໄປທີ່ ສູນການຊ່ວຍເຫລືອ HMO ຕາມໝາຍເລກ 1-888-466-2219. (Lao)

कृपया ध्यान दें: आप अपने डैंटिस्ट या डैंटल प्लान से संपर्क करने के लिए मुफ़्त में एक दोभाषिया प्राप्त कर सकते हैं। दोभाषिया प्राप्त करने के लिए या लिखित रूप में निवेदन करने के लिए (अपनी भाषा में या किसी अलग प्रारूप में, जैसे ब्रेल (Braile) या बड़े अक्षर)), पहले अपने डैंटल प्लान के फ़ोन नं 1-888-703-6999 पर कॉल करें। जो (आपकी भाषा बोलता हो), आपकी सहायता कर सकता है। अगर आपको और सहायता की ज़रूरत है, ऐचऐमओ (HMO) हैल्प सैंटर को 1-888-466-2219 पर कॉल करें। (Hindi)

เรื่องสำคัญ: ท่านสามารถใช้บริการล่ามได้ฟรีเพื่อช่วยในการคุยกับทันตแพทย์หรือปรึกษาเรื่องแผนการทำฟันของท่าน เพื่อขอใช้บริการล่ามหรือขอข้อมูลในรูปแบบเอกสาร (ในภาษาของท่านหรือในรูปแบบอื่น อย่างเช่น อักษรเบรลล์หรืออักษรขนาดใหญ่พิเศษ) กรุณาโทร์ไปยังเบอร์ของเราที่หมายเลข **1-888-703-6999** จะมีคนที่พูดภาษาไทยได้คอยช่วยเหลือท่าน ถ้าท่านต้องการความช่วยเหลือเพิ่มเติม กรุณาโทร์ไปที่ศูนย์ช่วยเหลือ **HMO** ที่หมายเลข **1-888-466-2219.** (Thai)

Discrimination is against the law. LIBERTY Dental Plan ("LIBERTY") follows State and Federal civil rights laws. LIBERTY does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

LIBERTY provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, please contact us between 8 a.m. to 5 p.m. (PST) by calling (888) 703-6999. Or, if you cannot hear or speak well, please call (800) 735-2929

HOW TO FILE A GRIEVANCE

If you believe that LIBERTY has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with LIBERTY's Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact LIBERTY's Civil Rights Coordinator, Monday through Friday, 8 a.m to 5 p.m (PST) by calling 888-704-9833. Or if you cannot hear or speak well, please call (800) 735-2929.
- In writing: Fill out a complaint form or write a letter and send it to:
  P.O. Box 26110
  Santa Ana, CA 92799
- In person: Visit your doctor's office or LIBERTY Dental Plan and say you want to file a grievance.
- Electronically: Visit LIBERTY Dental Plan website at https://www.libertydentalplan.com.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- In writing: Fill out a complaint form or send a letter to:

  Michele Villados
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.