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). If you are filing an **appeal**, you must sign and complete this form and **return it to LIBERTY within 15 days from the date you received it**.

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 the			
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 60 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, please contact Member Services at 1-866-609-0418

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

By providing LIBERTY with your signature, you are giving us your written permission to continue with the appeals process. If you do not sign and return this form, LIBERTY cannot continue with your appeal if it was received over the phone.

PLEASE SEND COMPLETED SIGNED FORM TO:	
LIBERTY Dental Plan of Nevada Quality Management Department P.O. Box 26110 Santa Ana, CA 92602-26110	**Or you may submit your grievance or appeal:** • By fax to LIBERTY's Quality Management Department fax at **(949) 270-0109** • Verbally by calling LIBERTY Dental Plan's Member Services Department at toll-free number: **(866) 703-6999**, or TTY: **(877) 855-8039** • By using our website online grievance filing process by visiting **www.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.