



WRITTEN MEMBER GRIEVANCE AND APPEAL FORM – FLORIDA

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 must 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:

Or you may submit your grievance or appeal:

LIBERTY Dental Plan of Nevada
Quality Management Department
P.O. Box 26110
Santa Ana, CA 92602-26110

- 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.**

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