

Provider Complaint Form



LIBERTY DENTAL PLAN

Making members shine, one smile at a time™

Office/Provider Information	Patient/Participant Information
Name:	Name:
Address:	Address:
Contact Person:	ID No.:
Phone:	DOB:
Fax:	Phone:

Select Reason for Your Complaint			
<input type="checkbox"/>	Plan Administration	<input type="checkbox"/>	Provider Reimbursement
<input type="checkbox"/>	Health Care Delivery	<input type="checkbox"/>	Contracting
<input type="checkbox"/>	Other		

Fill out the form completely and make sure you keep a copy for your records. Send this form and **all the necessary medical and/or dental documentation** to support your complaint to the following:

LIBERTY Dental Plan, Attn: Grievances and Appeals Department, P.O. Box 401086 Las Vegas, NV 89140, or you can fax us at:

1-833-250-1814 or email us at : GandA@libertydentalplan.com

Explanation of Your Issue(s):

Your complaint will be processed once all necessary documentation is received. You will receive an acknowledgement letter within 5 business days of the receipt of your complaint by the Plan. You will receive a response letter to your complaint within 30 calendar days.

Failure to submit all supporting documentation may delay our response to your complaint. If your complaint includes multiple members/patients, list them all separately.

Contact your LIBERTY Network Manager for questions or concerns by calling us at 1-866-609-0420.