

Provider Complaint Form



LIBERTY DENTAL PLAN

Making members shine, one smile at a time™

| Office/Provider Information | Patient/Member 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, P.O. Box 26110, Santa Ana, CA 92799-6110, or you can fax us at: **1-833-250-1814** or **email** us at: **GandA@libertydentalplan.com**

| Explanation of Your Issue(s): |
|-------------------------------|
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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 1-888-703-6999.