

California Dental Network, Inc.

1971 E 4th St Suite #184, Santa Ana, CA 92705

Grievance Form

Please complete **both sides** of this form and return to the mailing address shown above at your earliest convenience. Receipt from you will be acknowledged within five working days. All grievances will be resolved within 30 days whenever possible. If your grievance is urgent or an emergency please call the Plan toll-free at (877) 433-6825, for an immediate review. **Members who file a grievance against the Plan will not be discriminated or retaliated against in any way.**

MEMBER INFORMATION

Member Name: _____

Member Identification #: _____

Subscriber Name (if different from above): _____

Subscriber Identification # (if different from above): _____

Day Phone: () _____ Evening Phone: () _____

GRIEVANCE INFORMATION

Please use the back side of this form to describe your grievance in detail.

This grievance is being filed against (please check the appropriate box(es)):

Plan

Facility Personnel

Facility

Treating Provider

Date(s) Grievance Occurred: _____

FACILITY INFORMATION

Facility Name: _____ Facility Identification #: _____

Facility Address: _____

Treating Provider Name(s): _____

List the name(s) of facility personnel you spoke with about this matter: _____

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 **1-714-479-0777** or toll-free **1-877-4-DENTAL** 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 has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an 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.

