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WRITTEN MEMBER GRIEVANCE AND APPEAL FORM - CALIFORNIA

MEMBER INFORMATION (PLEASE PRINT)			
Member last name	Member first name	Today's date	
Member street address	City	State	Zip
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 CDN Dental Plan to allow the following person to act on my behalf during the grievance/appeals process		
Representative last name	Representative first name	Representative phone number
Representative Signature	Member Signature	

DENTAL OFFICE/PROVIDER INFORMATION (PLEASE PRINT)			
Office number	Dental office name	Date of last visit	
Dental office street address	City	State	Zip Code
Dental office phone number	Name of dental office staff involved (if known)		

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Medicaid Appeals must be filed within 60 calendar days from the date of your denial letter.

Medicaid Grievances can be filed at any time.

Commercial/Individual Appeals and Grievances much be filed within 180 calendar days from the date on your Denial Letter or from the event that causes your dissatisfaction.

If you need help completing this form, call our Member Services Department at [877-433-6825.] The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online. Monday through Friday 8:00 a.m. to 5:00 p.m. PST. We can give you an interpreter at no cost if you need one. You or someone you authorize have the right to review your case file at any time. We will give copies free of charge.

SUMMARY OF GRIEVANCE OR APPEAL (PLEASE PRINT)	
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

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PLEASE SEND THE COMPLETED SIGNED FORM TO:	
Mail to: **[2151 Michelson Drive, Irvine, CA 92612]**	• The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for hearing and speech impaired people. • Electronically using the website online grievance filing process by visiting **www.dmhc.ca.gov**
You will receive a letter acknowledging receipt of your grievance or appeal within 5 calendar days of receipt by California Dental Network (CDN). You will receive a written resolution to your standard grievance or appeal within 30 calendar days of receipt by California Dental Network (CDN).	

INDEPENDENT MEDICAL REVIEW (IMR)/EXTERNAL REVIEW

The paragraph below provides you with information on how to request an Independent Medical Review with DMHC. Note that the term grievance is talking about both complaints and appeals:

> 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 [**1-877-433-6825]** 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

INDEPENDENT MEDICAL REVIEW (IMR)/EXTERNAL REVIEW PROCESS

You have 6 months from any qualifying event to ask the Department of Managed Health Care to determine if your case meets the conditions for an Independent Medical Review (IMR)/External Review. You can ask for an IMR/External Review when you feel CDN, or your contracted dentist has incorrectly denied, modified, or delayed dental services as not medically necessary. You can also ask for an IMR/External Review for cases in which you received urgent care or emergency services that CDN denied due to medical necessity, experimental or investigational treatment, or payment disputes for emergency services.