DentaQuest
Benefits provided by California Dental Network

Grievance Form

Please complete this form and return to the mailing address shown below 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 **1-877-433-6825** 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 ☐ Facility Personnel ☐ 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: _____

_____

Definitions for Grievance Procedures

- "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative.
- "Complaint" is the same as "grievance."
- "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.
- "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.
- "Pending" grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system.

California Dental Network, Inc. DBA DentaQuest, 23291 Mill Creek Drive, Suite 100, Laguna Hills, CA 92653

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 **1-949-830-1600** or **toll free 1-877-4-DENTAL** and use your health plan's grievance process before contacting the department. For the hearing and speech impaired, dial **711** to call with the **Telecommunications Relay Service**. 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 website **www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Describe the Incident and Your Grievance (attach additional pages, if needed)

I authorize any dentist, doctor, hospital or other medical facility or professional to release any and all medical/dental records that relate to my grievance or that may affect the Plan's review and resolution.

Member Signature

Date

I give permission to California Dental Network, Inc. DBA DentaQuest to discuss this Grievance with the person(s) named below, including any pertinent medical/dental records and/or personal health information needed to assist in the processing of this Grievance.

Name(s) of Authorized Representative(s)

Member Signature

Date