# LIBERTY DENTAL PLAN® WRITTEN MEMBER GRIEVANCE AND APPEAL FORM – CALIFORNIA

Please use this form to help file a grievance or appeal with Liberty Dental Plan (Liberty). You can also use this form to give Liberty more information to help us review your case.

| MEMBER INFORMATION (PLEASE PRINT) | | | |
|---|---|---|---|
| *Member last name* | *Member first name* | *Today's date* | |
| *Member street address* | *City* | *State* | *ZIP code* |
| *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 Liberty 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) | | | |
|---|---|---|---|
| **I am authorizing Liberty Dental Plan to request my information, including chart records and x-rays, if applicable, from the following office:** | | | |
| *Office number* | *Dental office name* | *Date of last visit* | |
| *Dental office street address* | *City* | *State* | *ZIP Code* |
| *Dental office phone number* | *Name(s) of dental office staff involved (if known)* | | |

*Medicaid Appeals must be filed within 60 calendar days from the date on 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 **888-703-6999** or TTY **877-855-8039** 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 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**

| PLEASE SEND THE COMPLETED SIGNED FORM TO: | |
|---|---|
| Mail To:<br>**Liberty Dental Plan of California**<br>**Grievances and Appeals Dept.**<br>**P.O. Box 26110**<br>**Santa Ana, CA 92602-26110** | • Fax to Liberty's Grievances and Appeals Department fax at **833-250-1814**<br>• Telephone Liberty's Member Services Department at **888-703-6999**, or TTY **(877) 855-8039**<br>• Electronically using the website online grievance filing process by visiting **www.libertydentalplan.com** |
| You will receive a letter acknowledging receipt of your grievance or appeal within **5 calendar days** of receipt by Liberty.<br>You will receive a written resolution to your standard grievance or appeal within **30 calendar days** of receipt by Liberty. | |

## 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 **888-703-6999/TTY: 877-855-8039** 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 LIBERTY, 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 LIBERTY denied due to medical necessity, experimental or investigational treatment, or payment disputes for emergency services.