California Dental Network, Inc.
Provider Grievance Form

*Please complete **both sides** of 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. If your grievance is urgent or an emergency please call the Plan toll-free at (877)433-6825, for an immediate review.*

PROVIDER INFORMATION

Provider Name: ____

Provider Identification #:______________________________________

Facility Phone: ( ) ____________________________

GRIEVANCE INFORMATION

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

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

- ❑ Plan
- ❑ Referral Denial
- ❑ Member
- ❑ Claim Denial

Date(s) Grievance Occurred: ______________________________________

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.

DESCRIBE THE INCIDENT AND YOUR GRIEVANCE

(Use the backside of this form if necessary)

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The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number **(1-888-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-800-735-2929 (TTY) or 1-888-877-5378 (TTY))** to contact the department. The department's Internet website **(http://www.dmhc.ca.gov)** has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at **1-949-830-1600** or toll-free **1-877-4-DENTAL** and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

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Provider Signature *Date*