Managed DentalGuard

PO Box 4391 • Woodland Hills, CA 91365-4391 • 888-618-2016

Complaint Form

Please return the Complaint Form to the Quality of Care Liaison at the return address shown above.

MEMBER # or EMPLOYEE NUMBER	EMPLOYEE NAME	MANAGED DENTALGUARD PLAN #

ADDRESS:	HOME PHONE: ( )
	WORK PHONE: ( )
	FAX:

NAME AND NUMBER OF THE DENTAL OFFICE INVOLVED:

THIS COMPLAINT RELATES TO: ☐ Employee ☐ Dependent Name _____

PLEASE EXPLAIN YOUR GRIEVANCE:

_____

_____

_____

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WHAT ACTION WOULD YOU LIKE MDG TO TAKE?

_____

_____

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_____

MEMBER (OR MANAGED DENTALGUARD) SIGNATURE	DATE:

Please return the Complaint Form to the Quality of Care Liaison at the return address shown within fifteen (15) days from receipt. You will receive a response to your written complaint within thirty (30) days after MDG receives the Complaint Form.

NOT VALID IN TEXAS OR CALIFORNIA

Revised 2-2-98

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To: Dental Office: _____

Address: _____

City: _____

State: _____

Re: **AUTHORIZATION TO RELEASE INFORMATION**

You are hereby authorized to release to Managed DentalGuard and its representatives any and all information you may have concerning my dental condition, including x-rays, which you have obtained as a result of history, examinations, testing, diagnosis, treatment and progress.

Managed DentalGuard requests this information for the purposes of, including but not limited to, tge resikytuib if Nenber tekeogibe ir wrutteb gruevabcesm deternubatuib if Specialty Referral requests, the evaluation of patient records during on-site reviews and for the professional training of Managed DentalGuard Dental Consultants and Committee Members' review.

This Authorization shall remain valid for one (1) year from today's date. A faxed copy of this Authorization is as valid as the original.

I realize that I am entitled to have a copy of this signed Authorization and I **DO / DO NOT** (circle one) request a copy, and if requested, do acknowledge a receipt thereof.

I have read this Authorization before signing it.

_____ _____

Signature Type or Print Name

_____ _____

Social Security Number Date

If not signed by the patient, please indicate relationship:

[ ] Parent or Managed DentalGuard of minor patient
[ ] Managed DentalGuard or conservator of incompetent patient
[ ] Beneficiary or personal representative of deceased patient
[ ] Spouse or person financially responsible for the patient, where the dental information is being sought for the sole purpose of processing an application for health insurance or for enrollment in a nonprofit hospital plan, a health care service plan, or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan.

Revised 2-2-98