Managed DentalGuard
P.O. Box 4391 • Woodland Hills, CA 91365-4391 • 888-618-2016

(date)

-- Name, Address, City, State, Zip --

RE: (patient name)

Thank you for your recent comments informing Guardian of your concerns. Our member's feedback is an important ingredient of our continual improvement process so your comments are helpful to us. We appreciate having the opportunity to assist you.

If you would like Guardian to further review your complaint, please complete the enclosed Grievance Form and Authorization to Release Information and forward them to my attention at the address noted above within fifteen days from the date of this letter.

We assure you that we will respond to your written complaint within thirty days from the date we receive it.

Please feel free to contact me at 888-618-2016 if you have any questions.

Sincerely,

Anthony Abel
Quality of Care Liaison

Enclosures

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Complaint Form

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

EMPLOYEE SOCIAL SECURITY #	EMPLOYEE NAME	MDG PLAN SCHEDULE #

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:

WHAT ACTION WOULD YOU LIKE MDG TO TAKE?

MEMBER (OR GUARDIAN) SIGNATURE	DATE

Please return the Complaint Form to the Quality of Care Liaison at the return address shown within fifteen 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 Guardian 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.

Guardian requests this information for the purposes of, including but not limited to, the resolution of Member telephone or written grievances, determination of Specialty Referral requests, the evaluation of patient records during on-site reviews and for the professional training of Guardian Dental Consultants and Committee Members' review.

This Authorization shall remain valid for one 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 guardian of minor patient
[ ] Guardian 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.