

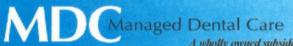
A wholly owned subsidary of The Guardian Life Insurance Company of America, New York, NY

P.O. Box 4391 Woodland Hills, CA 91365-4391

Grievance Form

MEMBER ID #:	SUBSCRIBER NA	SUBSCRIBER NAME:		GROUP #:	
ADDRESS:		HOME PHONE:	()	
		WORK PHONE:	()	
		FAX:	()	
NAME AND ID NUMBER OF	DENTAL OFFICE INVOLVED:				
THE CHEVANCE DE	ELATES TO: Subscr	ihan Danandant	Nama		
		ibei 🗀 Dependent	Name .		
PLEASE EXPLAIN Y	OUR GRIEVANCE:				
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WHAT ACTION WO	ULD YOU LIKE MD	C TO TAKE?			
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Note: 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 1-866-569-9900 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-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

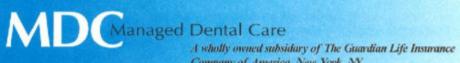


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Note: Free language assistance services are available for you and your dependents' to assist with your dental needs. Please contact MDC's Member Services Department at **1-866-569-9900**, your assigned network general dentist or your network specialist (for MDC approved specialty care) if English is not your or your dependents' preferred spoken or written language.

Nota: Los servicios gratuitos de ayuda con el idioma están disponibles para usted y sus dependientes para ayudarle con sus necesidades dentales. Si el inglés no es el idioma preferido de usted o sus dependientes, por favor comuníquese a nuestro Departamento de Servicios para Miembros al **1-866-569-9900**, su dentista general de red asignada o su especialista de red (para una atención especializada de MDC).



Company of America, New York, NY

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To:	Dental Office: Address: City: State:		
RE:	AUTHORIZ	ZATION TO RELEAS	E INFORMATION
repre whic	esentatives any and all in	formation you may have result of history, exam	ntal Care of California ("MDC") and its e concerning my dental condition, including x-rays, ination, testing, diagnosis, treatment
MDO	C requires this information	on for the purpose of res	olving my grievance.
	Authorization shall remarkable valid as the original.	ain valid for one year fr	om today's date. A signed copy of this Authorization
	lize that I am entitled to owledge receipt thereof.	have a copy of this sign	ed Authorization and if one is requested, do
Selec	ct ONE of the following	options:	
	[] MDC MAY provide written grievance.	the dentist(s) that is/ar	e subject of this grievance a copy of my
	[] MDC MAY NOT p my written grievand		t is/are subject of this grievance a copy of
	choice is indicated, M grievance is approved.	DC will understand th	at authorization to release a copy of
I hav	re read this Authorization	n before signing it.	
Sign	ature		Type or Print Name
Mem	nber ID Number		Date
If no	t signed by the patient, p	lease indicate relationsl	nip:
[] C [] B [] S for the	ne sole purpose of proces	of incompetent patient epresentative of decease ally responsible for the passing an application for ervice plan, or an emplo	health insurance or for enrollment in a nonprofit yee benefit plan, and where the patient is to be an