MDC Managed Dental Care
A wholly owned subsidiary of The Guardian Life Insurance Company of America, New York, NY

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

Grievance Form

Please return the Grievance Form to the Quality of Care Liaison at the return address listed above.

MEMBER ID #:	SUBSCRIBER NAME:	GROUP #:

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

NAME AND ID NUMBER OF DENTAL OFFICE INVOLVED:

THIS GRIEVANCE RELATES TO: ☐ Subscriber ☐ Dependent Name _____

PLEASE EXPLAIN YOUR GRIEVANCE:

_____

_____

_____

_____

WHAT ACTION WOULD YOU LIKE MDC TO TAKE?

_____

_____

MEMBER (OR LEGAL GUARDIAN) SIGNATURE:	DATE:

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).

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To: Dental Office: _____
Address: _____
City: _____
State: _____

RE: **AUTHORIZATION TO RELEASE INFORMATION**

You are hereby authorized to release to Managed Dental Care of California ("MDC") 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, examination, testing, diagnosis, treatment recommendations and/or treatment.

MDC requires this information for the purpose of resolving my grievance.

This Authorization shall remain valid for one year from today's date. A signed 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 if one is requested, do acknowledge receipt thereof.

Select ONE of the following options:

[ ] MDC **MAY** provide the dentist(s) that is/are subject of this grievance a copy of my written grievance.

[ ] MDC **MAY NOT** provide the dentist(s) that is/are subject of this grievance a copy of my written grievance.

If no choice is indicated, MDC will understand that authorization to release a copy of this grievance is approved.

I have read this Authorization before signing it.

_____ _____
Signature Type or Print Name

_____ _____
Member ID 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.