Managed DentalGuard, Inc.
P.O. Box 4391
Woodland Hills, CA 91365-4391

Complaint Form

MEMBER ID NUMBER:	SUBSCRIBER NAME:

ADDRESS:	HOME PHONE: ( )
	MOBILE PHONE: ( )

NAME AND ID NUMBER OF DENTAL OFFICE INVOLVED:

THIS COMPLAINT RELATES TO: ☐ Subscriber ☐ Dependent Name _____

PLEASE EXPLAIN YOUR COMPLAINT:

_____

_____

_____

_____

WHAT ACTION WOULD YOU LIKE MDG TO TAKE?

_____

_____

_____

_____

MEMBER (OR LEGAL GUARDIAN) SIGNATURE DATE:

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

VALID IN NEW JERSEY

Managed DentalGuard, Inc.
P.O. Box 4391
Woodland Hills, CA 91365-4391

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

RE: **AUTHORIZATION TO RELEASE INFORMATION**

You are hereby authorized to release to Managed DentalGuard, Inc. ("MDG") 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.

MDG requires this information for the purpose of resolving my written complaint.

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:

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

If no choice is indicated, MDG will understand that authorization to release a copy of this complaint 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.