Denti-Cal

California Medi-Cal Dental Program

NAME: _____ DATE: _____

ADDRESS 1: _____

ADDRESS 2: _____

CITY: _____ ST: ____ ZIP: _____

BENEFICIARY MEDI-CAL DENTAL PROGRAM COMPLAINT FORM

Please fill in the form below and describe your questions or complaints completely. This information is important and necessary to research and resolve your questions or complaints.

STATE OF CALIFORNIA MEDI-CAL
BENEFITS IDENTIFICATION CARD NUMBER: _____

TELEPHONE NUMBER: (_____) _____ - _____

MESSAGE TELEPHONE NUMBER: (_____) _____

YOUR REPRESENTATIVE (if not yourself):

NAME: _____

ADDRESS: _____

CITY: _____ , STATE: _____ ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____

YOUR DENTAL PROVIDER'S NAME: _____

NAME: _____

ADDRESS: _____

CITY: _____ , STATE: _____ ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____

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BENEFICIARY MEDI-CAL DENTAL PROGRAM COMPLAINT FORM (PAGE 2)

TYPE OF COMPLAINT:

_____ Dentist service was incomplete or unsatisfactory

_____ Clinical Screening process was unsatisfactory

_____ Other

_____ Comments (Please describe your questions or complaints/ grievances completely here. Use the reverse side of this form or additional pages if you need additional space.)

_____

_____

_____

_____

_____

PLEASE SIGN AND DATE THIS FORM:

It may be necessary to obtain your medical records from your dental care provider. Your signature below authorizes release of your dental records to Denti-Cal.

SIGNATURE_____ DATE_____

Return this form to: Medi-Cal Dental Program
Beneficiary Services Group
P.O. Box 15539
Sacramento, CA 95852-1539

When we receive this information, we will research your questions or complaints/grievances and notify you of our findings. If it is necessary for you to appear for a clinical examination in order to resolve this matter, we will notify you in writing of the date, time, and location of this appointment.

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Notice from the Department of Managed Health Care

You may file a complaint with the California Department of Managed Health Care after you have completed Delta's grievance process or after you have been involved in Denti-Cal's grievance process for 30 days. You may file a grievance with the Department immediately in an emergency situation that is one involving severe pain and imminent and serious threat to your health.

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 plan at **(1-800-322-6384)** and use your 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.

IMR has limited application to your dental program. You may request IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.