LIBERTY DENTAL PLAN

MEMBER GRIEVANCE AND APPEAL FORM – NEVADA

You can use this form to file a grievance or appeal with LIBERTY Dental Plan (LIBERTY).You can also use this form to give LIBERTY more information to help review your case. If you filed an **appeal over the telephone**, you can also complete this form and mail back to LIBERTY. This is optional. We will review your case without a written appeal.

MEMBER INFORMATION (PLEASE PRINT)			
Member last name	*Member first name*	*Today's date*	
Member street address	*City*	*State*	*ZIP code*
Member phone number	*Member identification number (see identification card)*		
Employer or Group	*Patient name*	*Relationship*	

AUTHORIZED REPRESENTATIVE INFORMATION, IF APPLICABLE (PLEASE PRINT)		
I am authorizing LIBERTY Dental Plan to allow the following person to act on my behalf during the grievance/appeals		
Representative last name	*Representative first name*	*Representative phone number*
Representative Signature	*Member Signature*	

DENTAL OFFICE/PROVIDER INFORMATION (PLEASE PRINT)			
I am authorizing LIBERTY Dental Plan to request my information, including chart records and x-rays, if applicable, from			
Office number	*Dental office name*	*Date of last visit*	
Dental office street address	*City*	*State*	*ZIP Code*
Dental office phone number	*Name(s) of dental office staff involved (if known)*		

Appeals must be filed within 60 days from the date on your Notice of Action (NOA)

Grievances can be filed at any time.

If you need help completing this form, call our Member Services Department at **1-866-609-0418,** Monday through Friday 8:00 a.m. to 5:00 p.m.**.** If you cannot hear or speak well, please call **1-800-952-8349.** If you need an interpreter, we will get you one at no cost. You or someone you authorize have the right to review your case file at any time. We'll give you copies free of charge.

SUMMARY OF GRIEVANCE OR APPEAL
Please share any information you have about your grievance or appeal. Please give us as many details as you can, if possible please provide the dates, names and any treatment. If needed, you can attach an additional page.
Please share with us how you would like to see your grievance or appeal resolved.

Member Signature Date

PLEASE SEND COMPLETED SIGNED FORM TO:	
Mail to: **LIBERTY Dental Plan of Nevada** **Grievances and Appeals Department** **P.O. Box 401086** **Las Vegas, NV 89140**	• Fax to LIBERTY's Grievances and Appeals Department at **1-833-250-1814** • Telephone by calling LIBERTY's Member Services Department at: **1-866-609-0418**, or TTY: **1-877-855-8039** • Electronically by using our website online grievance filing process by visiting **www.libertydentalplan.com/NVMedicaid**. • Emailing us at: **NVGandA@libertydentalplan.com**

You will receive a letter acknowledging receipt of your grievance or appeal within 5 calendar days of receipt by LIBERTY.
You will receive a written resolution to your grievance or appeal within 30 calendar days of receipt by LIBERTY.
You may request a copy of your records associated with your active grievance or appeal in writing to LI BERTY at the address listed above.