

# Member Grievance Form

*There are two sides to this form.  
Please print clearly.  
Complete all sections of this form.*

CIGNA Dental Health of California, Inc.



**MAIL TO:** National Appeals Unit  
P.O. Box 188047  
Chattanooga, TN 37422-8047  
Member Services: 1.800.244.6224 Toll Free  
1.800.321.9545 (TTY)

**OR FAX:** 1.866.870.3842 Toll Free

I am submitting a grievance to CIGNA Dental Health of California, Inc. ("CIGNA Dental")

**IN AN EMERGENCY, PLEASE CALL 911 OR GO DIRECTLY TO THE NEAREST EMERGENCY ROOM.**

**Check this box if this case involves an imminent and serious threat to you or the health of the patient, including but not limited to, severe pain, the potential loss of life, limb or major bodily function. If it does, please phone CIGNA Dental Member Services at 1-800-244-6224 or the toll free number on your CIGNA Dental Identification Card. Hearing impaired or TTY users dial 711 to reach the California Relay Service and provide the operator with the CIGNA Dental phone number.**

*To serve you quickly, it is important that you provide as much information as possible. If you have any questions about the meaning of anything on this Form, please call Member Services at 1-800-244-6224 or the toll free telephone number on your CIGNA Dental Identification Card.*

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 **1-800-244-6224 or the toll-free telephone number on your CIGNA identification card (1-800-321-9545 (TTY) for the hearing and speech impaired)** 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.

<b>MEMBER INFORMATION (Member complete this information)</b>			
Name (Last)	(First)	(Middle Initial)	Member Identification Number
Mailing Address (Street)		(City)	(State) (Zip Code)
Daytime Telephone Number ( )	Evening Telephone Number ( )	E-Mail Address	
Name of Person filing Grievance (if other than member)			
<b>PATIENT INFORMATION (Complete only if patient is other than member)</b>			
Name (Last)	(First)	(Middle Initial)	Relationship to Member
Mailing Address (Street)		(City)	(State) (Zip Code)
Daytime Telephone Number ( )	Evening Telephone Number ( )	E-Mail Address	

*(Continued on Reverse Side)*

**DENTAL SERVICES INFORMATION**

Dentist Name (Last)	(First)	(Middle Initial)	Date of Service
Address (Street)	(City)	(State)	(Zip Code)
Dental Office Number	Dental Office Telephone Number ( )		
Nature of Problem: <input type="checkbox"/> Dentist's Service <input type="checkbox"/> Charges <input type="checkbox"/> Attitude of Dentist <input type="checkbox"/> Other: _____ <input type="checkbox"/> Benefits <input type="checkbox"/> Appointment <input type="checkbox"/> Attitude of Dental Staff			
Description of Problem:			
May we send a copy of this form to the Dentist you named above? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>CERTIFICATION</b>			
<b>I certify that this information is true and correct.</b>			
Member/Patient Signature			Date

**WHEN COMPLETED, MAIL THIS FORM TO:**

CIGNA Dental Health of California, Inc.  
P.O. Box 188047  
Chattanooga, TN 37422-8047

**OR, FAX IT TO:**    866-870-3842 Toll Free

**FOR INTERNAL USE ONLY:**

Initial Determination     Complaint     Appeal