

**Cigna Dental Health of California, Inc.
California Customer Grievance Form**



IMPORTANT: There are two sides to this form. Complete all sections. Please print clearly.

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

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

Please check here 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 Customer Service at **1.800.Cigna24** (1.800.244.6224) or the toll-free number on your Cigna Dental Identification Card. Those who are hearing impaired or TTY users may dial 711 to reach the California Relay Service and provide the operator with the Cigna Dental phone number.

IMPORTANT: 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 Cigna Customer Service at **1.800.Cigna24** (1.800.244.6224) or the toll-free telephone number on your Cigna Dental Identification Card.

The California Department of Managed Health Care ("Department") 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.Cigna24** (1.800.244.6224) or the toll-free telephone number on your Cigna identification card for the hearing and speech impaired (**1.800.321.9545 – TTY**).

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 an 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 of **1.888.HMO.2219** (1.888.466.2219) and a TDD line (**1.877.688.9891**) for the hearing and speech impaired. The Department's website, **HMOhelp.ca.gov** has complaint forms, IMR application forms, and instructions online.

CUSTOMER INFORMATION (Customer to complete this information)			
Name (Last)	(First)	(Middle Initial)	Customer ID Number
Mailing Address (Street)		(City)	(State) (Zip Code)
Daytime Telephone Number	Evening Telephone Number	Email Address	
Name of Person Filing the Grievance (if other than customer)			

PATIENT INFORMATION (Complete only if patient is other than the customer)			
Name (Last)	(First)	(Middle Initial)	Relationship to Customer
Mailing Address (Street)		(City)	(State) (Zip Code)
Daytime Telephone Number	Evening Telephone Number	Email Address	

(Continued on Back)

DENTAL SERVICES INFORMATION

Dentist Name (Last)	(First)	(Middle Initial)	Date of Service
Mailing Address (Street)		(City)	(State) (Zip Code)
Dental Office Number		Dentist 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			

CERTIFICATION

I certify that this information is true and correct.

Customer/Patient Signature	Date
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When completed, mail or fax this form.

Mail: Cigna Dental Health of California, Inc.
National Appeals Unit
P.O. Box 188047
Chattanooga, TN 37422-8047

Fax: 866.870.3842 (toll free)

AREA FOR CIGNA USE ONLY

Initial Determination Complaint Complaint Appeal

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