SafeGuard Health Plans, Inc.

GRIEVANCE FORM

California

Please complete this form and return it to SafeGuard at the address listed below to enable prompt resolution of your complaint. SafeGuard will send you an acknowledgement letter within five (5) days of receipt of this form. SafeGuard will review your complaint and send you written notice of the determination within thirty (30) days of receipt of this form. If your complaint is not resolved by SafeGuard to your satisfaction, you may contact the California Department of Managed Health Care as set forth below. A copy of this form may be forwarded to the dental or vision provider who provided treatment.

SECTION 1: Member Information

Member Name	Family ID Number

Address	Apt/Suite # (If any)

City	State	Zip

Member Home Phone No	Work Phone No

Patient Name	Relationship to Member

Patient Home Phone No	Patient Work Phone No

SECTION 2: Employer Information

Employer Name	Employer Group Number

Dental/Vision Facility Name	City

SECTION 3: Authorization

If you need assistance in completing this form, please contact the Customer Service Department at 800.880.1800. You may also refer to your Evidence of Coverage for a detailed description of the complaint process.

I authorize the release and disclosure of any and all of my dental/vision records to SafeGuard Health Plans, Inc., Quality Management Department.

Signature: _____ **Date:** _____

Please state your complaint on the reverse side of this document, or attach a separate form and mail the completed form to:

Quality Management Department
P.O. Box 3532
Laguna Hills, CA 92654-3532

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 **1-800-880-1800** 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

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LANGUAGE ASSISTANCE

As a SafeGuard member you have a right to free language assistance services, including interpretation and translation services. SafeGuard collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require language assistance or would like to inform SafeGuard of your preferred language, please contact SafeGuard at **(800) 880-1800**.

Como miembro de SafeGuard usted tiene derecho a recibir servicios gratuitos de asistencia en idiomas. Esto incluye servicios de interpretación y traducción. SafeGuard recaba la información sobre sus preferencias de idioma, raza, y etnia de manera que nos podamos comunicar eficazmente con nuestros afiliados. Si necesita asistencia en su idioma o quiere informarle a SafeGuard sobre su idioma de preferencia, comuníquese con SafeGuard al **(800) 880-1800**.

作為SafeGuard的會員，您有權獲得免費語言服務，包括口譯和筆譯。SafeGuard收集並保存有關您的語言選擇、人種和族裔方面的資料，以便我們更有效地與會員溝通。如果您需要語言方面的協助，或希望將您選擇的語言告訴SafeGuard，可通過電話或網站與SafeGuard聯絡，電話是(800) 880-1800。