SafeGuard Health Plans, Inc.

GRIEVANCE FORM

Florida

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 request an appeal by writing to SafeGuard, or you may contact the Florida Department of Financial Services as listed below. A copy of this form may be forwarded to the dental or vision provider who provided treatment.

SECTION 1: Member Information

Member Name	Facility 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	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

Members always have the right to file a complaint with or seek assistance from the Florida Department of Financial Services, Consumer Complaints Division, State Capitol Larson Building, 200 East Gaines Street, Room 637, Tallahassee, FL 32399-0300 or by calling (800) 342-2762.

Complaint:

SafeGuard Health Plans, Inc.

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