Grievance Form

Metropolitan Life Insurance Company MetLife Health Plans, Inc.
SafeGuard Health Plans, Inc.

This grievance form was downloaded from MetLife's website. Please complete this form and return it to MetLife at the address listed below to enable prompt resolution of your complaint. MetLife will send you an acknowledgement letter within five (5) days of receipt of this form. MetLife will review your complaint and send you written notice of the determination within thirty (30) days of receipt of this form. [1] City:

Member's Name: ______________________ Family ID Number: ______________________

Member's Home Address: ____

__________________________ State: ______________ Zip: ______________

Member Home Phone: ______________________ Work: ______________________

Patient's Name: ______________________ Relationship to Member: ______________________

Patient's Home Phone No.: ______________________ Work Phone No.: ______________________

Employer's Name: ______________________ Employer's Group No.: ______________________

Dental/Vision Facility Name: ______________________ City: ______________________

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 MetLife, 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:

MetLife
c/o Quality Management Department
P. O. Box 3532
Laguna Hills, CA 92654-3532

[1] Residents of NY we will provide a written response to your complaint within fifteen (15) business days of receipt.

MetLife

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