SUBSCRIBER GRIEVANCE / COMPLAINT FORM

GOLDEN WEST DENTAL & VISION
PO BOX 659471
SAN ANTONIO, TX 78265
www.goldenwestdental.com

Member's Name: _____ Mbr ID#:_____

Patient's Name: _____

Address: _____

City: _____ Zip: _____Phone#: _____

Grievance / Complaint (Please provides as much detailed information as possible):

_____

_____

_____

_____

What is your recommendation for resolution? _____

_____

_____

(Attach additional paper to this form if necessary)

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 **1-866-926-8078** or at the TDD/TTY line **711** 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 **(1-888-466-2219)** 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.

_____ _____ _____

Member Number Signature Date