Appeal Request Form

If you have a complaint or grievance, please complete, and submit this form to LIBERTY Dental Plan ("LIBERTY") to start the Grievances/Appeals Process. The completed form must be received by LIBERTY **within sixty (60) days of the triggering event.** This is the date on which the event you are appealing occurred.

Failure to complete and return this form within sixty (60) days can result in dismissal or denial of your grievance or appeal.

Please provide all requested information, including a complete explanation of the problem/issue. Include the name(s) of any LIBERTY people you have dealt with, and the dates on which specific events occurred. Use more paper if necessary. Attach copies of any supporting documents you would like to be considered.

Enrollee Information

Enrollee Name: ____ Enrollee ID: _______________

Enrollee Mailing Address: ____

City: ____State: ________Zip Code: _________________

Phone Number: _______________________________Email Address: __________________________

Date of Triggering Event: ____

Enrollee's Guardian (if applicable): _______________________Guardian Phone: __________________

Authorized Representative (if any)

I, ________________________authorize _______________________ to serve as my Representative in connection with the grievance/appeal. I authorize my Representative to present evidence, to obtain information about my grievance/appeal, and to receive notices in connection with my grievance/appeal. I understand that my personal health information (PHI) may be disclosed to my Representative. I understand that my PHI may include information about drug or alcohol disorders or treatment, mental health disorders or treatment, and communicable or non-communicable diseases. By signing this form, I am authorizing disclosures of this information. My Representative will be available to represent me on the date and time of the grievance/appeal hearing as set by LIBERTY. I do not have a legally appointed Guardian, or my legally appointed Guardian hereby consents to this authorization.

____

Member Signature Date

____

Authorized Representative Signature Date

SoonerSelect

LIBERTY DENTAL PLAN

Please tell us about your request in the space below. Be as specific as possible and when possible, give the date(s) that the event occurred. Please include what you would like LIBERTY to do about this issue. *(If you need more space, use another sheet of paper.)*

IMPORTANT NOTICE FOR ENROLLEES OF SOONERSELECT BENEFITS OR SERVICES WHOSE BENEFITS OR SERVICES WERE DISCONTINUED OR REDUCED:

You must request an appeal and your appeal must be received by LIBERTY. Your appeal must be filed within sixty (60) calendar days of the date of your notice. You can ask for your services to continue while your appeal is reviewed. You must ask for services to be continued within ten (10) calendar days of the date of your notice. You can also ask for your services to stop while your appeal is reviewed. If you file for an appeal within 60 calendar days of the date of your notice and do not ask for your services to stop, they will be continued during the review period. When your appeal doesn't change the health plan's decision, the health plan may require you to pay for the services you received while waiting for a decision.

☐ I **do not** want services or benefits to continue while my appeal is being decided.

Enrollee Signature ______________________ ***Date*** ______________

Please send this form to:

LIBERTY Dental Plan
Attn: Grievances & Appeals
P.O. Box 26110 Santa Ana, CA 92799

Phone: 888-700-1093 or TTY: 877-855-8039
Email: GandA@libertydentalplan.com