LIBERTY DENTAL PLAN

WRITTEN PROVIDER GRIEVANCE AND APPEAL FORM – NEVADA

Please use this form to help file a grievance or appeal with LIBERTY Dental Plan (LIBERTY). If you filed a verbal **appeal with the Member Services Department**, you must sign and complete this form and **return it to LIBERTY within 15 days from the date you received it**. If you are filing an **appeal on behalf of a member**, you must include signed authorization from the member.

DENTAL OFFICE/PROVIDER INFORMATION (PLEASE PRINT)			
I am authorizing LIBERTY Dental Plan to request my information, including chart records and x-rays, if applicable, from			
Office number	*Dental office name*	*Today's date*	
Dental office street address	*City*	*State*	*ZIP Code*
Claim/TAR No.:	*Denial reason(s):*		

AUTHORIZED REPRESENTATIVE INFORMATION, IF APPLICABLE (PLEASE PRINT)		
I am authorizing LIBERTY Dental Plan to allow the following person to act on my behalf during the grievance/appeals		
Representative last name	*Representative first name*	*Representative phone number*
Representative Signature	*Member Signature*	

MEMBER INFORMATION (PLEASE PRINT)			
Member last name	*Member first name*		
Member street address	*City*	*State*	*ZIP code*
Member phone number	*Member identification number (see identification card)*		

Medicaid Providers may file a Grievance or Appeal within 90 days from the date of LIBERTY's initial decision.

If you need help completing this form, please contact Member Services at 1-866-609-0418

SUMMARY OF GRIEVANCE OR APPEAL
Please share any information you have about your grievance or appeal. Please ensure that you provide additional documentation to support your grievance or appeal. If needed you can attach an additional page.

Provider Signature Date

By providing LIBERTY with your signature, you are giving us your written permission to continue with the appeals process. If you do not sign and return this form, LIBERTY cannot continue with your appeal if it was received over the phone.

PLEASE SEND COMPLETED SIGNED FORM TO:	
LIBERTY Dental Plan of Nevada Quality Management Department 6385 S. Rainbow Blvd., Suite 200 Las Vegas, NV 89118	**Or you may submit your grievance or appeal:** • By fax to LIBERTY's Quality Management Department fax at **(833) 250-1814** • Verbally by calling LIBERTY Dental Plan's Member Services Department at toll-free number: **(866) 609-0418**, or TTY: **(877) 855-8039** • By using our website online grievance filing process by visiting **www.libertydentalplan.com**.
You will receive a letter acknowledging receipt of your grievance or appeal within 5 calendar days of receipt by LIBERTY. You will receive a written resolution to your grievance and/or appeal within 30 calendar days of receipt by LIBERTY.	