Grievance Form

MEMBER ID NUMBER:	SUBSCRIBER NAME:	GROUP NUMBER:

ADDRESS:	HOME PHONE: ( )
	WORK PHONE: ( )
	FAX: ( )

NAME AND ID NUMBER OF DENTAL OFFICE INVOLVED:

THIS GRIEVANCE RELATES TO: ☐ Subscriber ☐ Dependent Name _____

PLEASE EXPLAIN YOUR GRIEVANCE:

_____

_____

_____

_____

WHAT ACTION WOULD YOU LIKE GUARDIAN TO TAKE?

_____

_____

_____

_____

MEMBER (OR LEGAL GUARDIAN) SIGNATURE DATE:

Please return the Grievance Form along with all related documents to the Quality of Care Liaison at the return address shown within thirty (30) days from receipt. You will receive a response to your written grievance within thirty (30) calendar days after Guardian receives the Grievance Form.

VALID IN NEW YORK

To: Dental Office: _____
Address: _____
City: _____
State: _____

RE: **AUTHORIZATION TO RELEASE INFORMATION**

You are hereby authorized to release to The Guardian Life Insurance Company if America ("Guardian") and its representatives any and all information you may have concerning my dental condition, including x-rays, which you have obtained as a result of history, examination, testing, diagnosis, treatment recommendations and/or treatment.

Guardian requires this information for the purpose of resolving my written grievance.

This Authorization shall remain valid for one year from today's date. A signed copy of this Authorization is as valid as the original.

I realize that I am entitled to have a copy of this signed Authorization and if one is requested, do acknowledge receipt thereof.

Select ONE of the following options:

[ ] Guardian **MAY** provide the dentist(s) that is/are subject of this grievance a copy of my written grievance.

[ ] Guardian **MAY NOT** provide the dentist(s) that is/are subject of this grievance a copy of my written grievance.

If no choice is indicated, Guardian will understand that authorization to release a copy of this grievance is approved.

I have read this Authorization before signing it.

_____ _____
Signature Type or Print Name

_____ _____
Member ID Number Date

If not signed by the patient, please indicate relationship:

[ ] Parent or guardian of minor patient
[ ] Guardian or conservator of incompetent patient
[ ] Beneficiary or personal representative of deceased patient
[ ] Spouse or person financially responsible for the patient, where the dental information is being sought for the sole purpose of processing an application for health insurance or for enrollment in a nonprofit hospital plan, a health care service plan, or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan.