DELTA DENTAL

Federal Government Programs

Patient Grievance Form

Delta Dental assures enrollees access to quality, affordable and necessary dental care when provided by participating network dentists. All grievances are taken seriously and are acknowledged, researched and monitored through final resolution.

Enrollee requests for Delta Dental to investigate grievances must be submitted in writing to the address below. Document the details of the grievance on the reverse side of this form and specify the desired outcome. Include a copy of all records, documents, billing statements, etc., to support the grievance.

Delta Dental of California
Federal Government Programs
P.O. Box 537015
Sacramento, CA 95853-7015

Depending on the nature of the grievance, staff in various Delta Dental departments may be involved in researching and contributing to the final resolution. The final disposition of each grievance will be personally reviewed and approved by the supervising manager.

If the grievance involves an immediate and serious threat to the health of the patient, immediately contact the Customer Service department at 888-838-8737.

Delta Dental will acknowledge receipt of all written grievances within 30 calendar days.

REQUIRED INFORMATION

Patient

Name: _____ Date of Birth: _____

Phone Number: _____ Alternate Phone Number: _____

Relationship to Primary Enrollee: ☐ SELF ☐ SPOUSE ☐ CHILD

Primary Enrollee

Name: _____ SSN: _____

Address: _____

City, State, ZIP: _____

Dentist

Name: _____

Address: _____

City, State, ZIP: _____ Phone Number: _____

TREATMENT INFORMATION

Date(s) treatment provided: _____

Was treatment completed?	☐ Yes	☐ No
Have you discussed the matter with the dentist or staff?	☐ Yes	☐ No
If an agreeable solution could be reached, would you return to the dentist?	☐ Yes	☐ No

NATURE OF GRIEVANCE

Provide the specific details of your complaint. Attach additional paper if necessary.

I understand the importance of providing information as completely and accurately as I can, and that failure to do so may delay, or even prevent, further consideration of a resolution on my grievance. I understand that a copy of this grievance may be sent to the dentist who provided treatment.

Signature: _____ Date: _____