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: _____________________________