

**PRIMECARE DENTAL PLAN**  
**Complaint Form (Reverse Side)**  
**THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975**

PrimeCare Dental Plan is subject to the requirements of Chapter 2.2 of Division 2 of California Health and Safety Code and Subchapter 5.5 of Chapter 3 of Title 28 of the California Administrative Code. Any provision required to be in the Subscriber Agreement binds the Plan whether or not included in your subscriber agreement, i.e. the Plan Contract.

**Alternative remedies available to you include the following:**

1. The mailing of a completed complaint form to PrimeCare Dental Plan. Complaints may also be made by telephone to the numbers set forth on the front of this Complaint Form or by visiting our website [www.primecaredental.net](http://www.primecaredental.net)
2. The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number **1-800-400-0815** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll free **telephone numbers 1-800-735-2929 (TTY) or 1-888-877-5378** to contact the department. The department's Internet **website (<http://www.hmohelp.ca.gov>)** has complaint forms and instructions online. If you have a grievance against a health plan, you should contact the plan and use the plan's grievance process. If you need the department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the plan, you may call the department's toll-free telephone number. complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the plan, you may call the department's toll-free telephone number.
3. A request to the Plan for voluntary mediation with each party sharing equally in the costs of mediation. This alternative may be exercised at any time.
4. After completing the grievance or participating in the process for at least 30 days, the grievance or complaint may be submitted to the Department of Managed Health Care for review.
5. PrimeCare will expedite review of grievances for cases involving an imminent and serious threat to the health of the patient including but not limited to, severe pain, potential loss of life, limb, or major bodily function. When PrimeCare has notice of a case requiring expedited review, PrimeCare will immediately inform enrollees in writing of their right to notify the Department of Managed Care. When a grievance is expedited for review, PrimeCare will provide the enrollee and the Department of Managed Care with a written statement on the disposition or pending status of the grievance within three days from receipt of the grievance.

Failure to engage in the grievance process does not preclude you from using any other remedy provided by law.

PrimeCare Dental has implemented a language assistance program for all members. If you would prefer to speak in any language other than English, free interpretation services are available. To request for services in a language other than English, please call PrimeCare Dental at (800) 937-3400 and a customer service representative will transfer you to the appropriate interpreting services to assist you with any issues relating to the services provided to you by PrimeCare Dental.

Remember, we are as close as your telephone. Your dental health and welfare is important to us.

**Mail to:** PrimeCare Dental Plan 10700  
Civic Center Dr. Ste 100-A Rancho  
Cucamonga, CA 91730  
**Or Fax to:** (909) 483-5351



## PRIMECARE DENTAL PLAN

### Confidential Grievance Form

Member Information (Form completed by)		
Name:	Member ID:	Plan:
Address:		
City:	State:	ZIP Code:
Phone:		
Provider Number:	Provider Name:	
Provider Address:		
City:	State:	ZIP Code:
Please state your comments, grievance or injury, time, date and relevant facts (use additional page if needed)		
Desired resolution:		
Signature: _____	Date: ____ / ____ / ____	

#### English

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at (800) 937-3400.

#### Spanish

**IMPORTANT:** ¿Puede usted leer esta carta? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta carta en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al (800) 937-3400

The California Department of Managed Health Care is responsible for regulating healthcare service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-937- 3400** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that maybe available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30days, you may Call the department for assistance. You may also be eligible for an Independent Medical Review (IMR}. If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a **toll-free number (1-888-HMO-2219)** and a **TDD line (1-877- 688-9891)** for the hearing and speech impaired. The department's Internet **Website <http://www.hmohelp.ca.gov>** has complaint forms, IMR application forms and instructions online.