

TRICARE Retiree Dental Program

Patient Grievance Form

Delta Dental assures TRDP 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. Such grievances must be documented on the reverse side of this form and must specify the grievance with requested outcome and any additional records, documents or billing information to support the grievance.

Delta Dental of California
Federal Services Division
PO 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 provided? 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

Explain who, what, when, where and how. 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 send to the dentist who provided treatment.

Signature: _____ Date: _____