GUARDIAN℠

QUALITY OF CARE COMPLAINT/GRIEVANCE FORM

MEMBER INFORMATION

MEMBER/INSURED NAME	MEMBER ID	GROUP #

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	RELATIONSHIP TO MEMBER/INSURED

ADDRESS	CONTACT # ( ) SECONDARY CONTACT # ( ) EMAIL ADDRESS:

TREATING DENTIST INFORMATION (Dentist you are filing complaint about)

DENTIST NAME	DENTIST CONTACT # ( )
ADDRESS	

SUBSEQUENT TREATING DENTIST INFORMATION (Dentist you had a second opinion with)

DENTIST NAME	DENTIST CONTACT # ( )
ADDRESS	

Please complete a separate Authorization to Release Records form for each dentist named above.

COMPLAINT SUMMARY

CLAIM NUMBER(s)	DATES OF SERVICE

BRIEFLY SUMMARIZE YOUR COMPLAINT/GRIEVANCE

WHAT ACTION WOULD YOU LIKE GUARDIAN TO TAKE?

SIGNATURE OF MEMBER, PATIENT OR LEGAL GUARDIAN	DATE

Return the completed and signed packet and authorization forms to:
The Guardian Life Insurance Company of America Complaints & Grievances Department, PO Box 4391, Woodland Hills CA 91367
Or Via Email to **Complaints_Grievances@glic.com**