Managed DentalGuard, Inc.
P.O. Box 4391
Woodland Hills, CA 91365-4391

Complaint Form
(Formulario Para Quejas)

MEMBER ID # (NÚMERO DE IDENTIFICACIÓN DEL MIEMBRO)	SUBSCRIBER NAME (NOMBRE DEL SUBSCRIPTOR)	GROUP # (NÚMERO DE GRUPO)

ADDRESS (DIRECCIÓN)	HOME TELEPHONE # (TELÉFONO CASA) ( )
	WORK TELEPHONE # TELÉFONO TRABAJO ( )
	FAX ( )

NAME AND # OF THE DENTAL OFFICE INVOLVED (NOMBRE Y NÚMERO DE LA OFICINA DENTAL INVOLUCRADA):

THIS COMPLAINT RELATES TO (ESTA QUEJA SE RELACIONA CON):

Name (Nombre): ______________________________ Subscriber (El Subscriptor) Dependent (Un dependiente)

PLEASE EXPLAIN YOUR GRIEVANCE (POR FAVOR EXPLICAR EL MOTIVO DE LA QUEJA):

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____
____

WHAT ACTION WOULD YOU LIKE MDG TO TAKE? (¿QUE ACCION DESEARIA USTED QUE TOME MDG?)

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____
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SUBSCRIBER SIGNATURE (FIRMA DEL SUBSCRIPTOR)	Date (Fecha)

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MDG's toll-free number for information or make a complaint at:
1-844-561-5600

You may contact the Texas Department of Insurance to obtain information on companies, coverage, rights or complaints at:
1-800-252-3439

You may write the Texas Department of Insurance at:
P.O. Box 149104
Austin, TX 78714-9104
FAX #: (512) 475-1771

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar al nímero de teléfono gratis de MDG pare información o para someter una queja al:
1-844-561-5600

Puede communicarse con el Departamento de Seguros de Texas para obtener informacion acerca de compañias, coberturas, derechos o quejas al:
1-800-252-3439

Puede escribir al Departamento de Seguros de Texas al:
P.O. Box 149104
Austin, TX 78714-9104
FAX #: (512) 475-1771

Please return the Complaint Form to the Quality of Care Liaison at the return address shown within thirty (30) calendar days from receipt. You will receive a response to your written complaint within thirty (30) calendar days after MDG receives the Complaint Form.
(Por favor devuelva el Formulario para quejas al Quality of Care Liaison a la dirección que se muestra dentro de treinta (30) días hábiles de haber recibido el formulario. Usted recibirá una respuesta a su queja escrita dentro de treinta (30) días hábiles después de que MDG reciba el Formulario para quejas.)

Managed DentalGuard, Inc.
P.O. Box 4391
Woodland Hills, CA 91365-4391

To: Dental Office: ___________________________________
Address: ___________________________________
City: ___________________________________
State: ___________________________________

RE: **AUTHORIZATION TO RELEASE INFORMATION**

You are hereby authorized to release to Managed DentalGuard, Inc. ("MDG") and its representatives any and all information you may have concerning my dental condition, including x-rays, which you have obtained as a result of history, examination, testing, diagnosis, treatment recommendations and/or treatment.

MDG requires this information for the purpose of resolving my written complaint.

This Authorization shall remain valid for one year from today's date. A signed copy of this Authorization is as valid as the original.

I realize that I am entitled to have a copy of this signed Authorization and if one is requested, do acknowledge receipt thereof.

Select ONE of the following options:

[ ] MDG **MAY** provide the dentist(s) that is/are subject of this complaint a copy of my written complaint.

[ ] MDG **MAY NOT** provide the dentist(s) that is/are subject of this complaint a copy of my written complaint.

If no choice is indicated, MDG will understand that authorization to release a copy of this complaint is approved.

I have read this Authorization before signing it.

_______________________________________ _________________________________
Signature Type or Print Name

_______________________________________ _________________________________
Member ID Number Date

If not signed by the patient, please indicate relationship:

[ ] Parent or guardian of minor patient
[ ] Guardian or conservator of incompetent patient
[ ] Beneficiary or personal representative of deceased patient
[ ] Spouse or person financially responsible for the patient, where the dental information is being sought for the sole purpose of processing an application for health insurance or for enrollment in a nonprofit hospital plan, a health care service plan, or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan.