GRIEVANCE FORM

Please complete the following form completely. Accurate and complete information will help The CDI Group to resolve your grievance promptly. Once completed the Grievance Form should be mailed to The CDI Group at:

The CDI Group, Inc.
601 Daily Drive, Suite 215
Camarillo, CA 93010
ATTN: Grievance Resolution Department

You do not have to use this Grievance Form if you do not want to. You can submit your grievance to The CDI Group by telephone at **1-855-257-2533**, or you can complete a Grievance Form on-line at your respective plan's website. For Dental Alliance Dental Plan the web address is: www.dentalalliancedentalplan.com/support.

Can you read this document? If not, call The CDI Group at **1-855-257-2533** for free language assistance. ¿Puedes leer este documento? Puedes llama Al Grupo CDI en (800) 874-1986 para recibir asistencia lingüística gratuita.

California law requires The CDI Group to provide you with the following notice:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-855-257-2533** 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 may be 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 30 days, 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 telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online."

Please write as legibly as you can.

1. Name of Grievant (in full, including middle initial):________________________

2. If the Grievant is a dependent of the Subscriber (the person who signed the contract

with The CDI Group) the full name of the Subscriber (including middle initial): ____

3. Subscriber Number:____

4. Grievant's Address and Telephone Number:
_________________________________[street] ______________________[apt.]

__________________________[city], ________________[state] ___________[zip code]

( )________________________________[tel. no.]

5. If this grievance is prepared by someone other than the Grievant, state:

____[full name of preparer]

_________________________________[relationship to Grievant]

( )________________________________[preparer tel. no.]

6. Name of the Grievant's Network Dentist:

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7. Address of the Grievant's Network Dentist:

____ [street]

____________________________ [city], ____________________________ [state]

8. Describe your grievance. Be as specific and as thorough as you can. If applicable, specify the relevant date or dates when the event or events occurred. Attach additional sheets if necessary.

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G Check here if additional sheet(s) are attached. Number of additional sheets:__________