

Cigna Dental California Customer Dissatisfaction Form



We are interested in your satisfaction with our dental plan and your network dental office. If you have encountered any difficulties, please complete this form so we may review the circumstances and attempt to resolve the problem. Your information will help us assist you and improve our program. **When completed, mail this form to Cigna Dental Health of California, Inc., P.O. Box 188047, Chattanooga, TN 37422-8047 or fax it to 1.866.870.3842 (toll free).**

PATIENT/SUBSCRIBER INFORMATION

Patient		Subscriber	
Address			
Social Security No.		Employer	
Home Phone No.		Business Phone No.	

DENTAL SERVICES INFORMATION

Dentist		Date of Service	
Address			
Dental Office No.		Dental Office Telephone No.	
Nature of Problem <input type="checkbox"/> Dentist's Service <input type="checkbox"/> Charges <input type="checkbox"/> Attitude of Dentist <input type="checkbox"/> Other: _____ <input type="checkbox"/> Benefits <input type="checkbox"/> Appointment <input type="checkbox"/> Attitude of Dental Staff			
Description of Problem			
May we send a copy of this form to the Dentist you named above? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Signature		Date	

The California Department of Managed Health Care ("Department") 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 **1.800.367.1037** 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 of **1.888.HMO.2219** (1.888.466.2219) and a TDD line (**1.877.688.9891**) for the hearing and speech impaired. The Department's website, **HMOhelp.ca.gov**, has complaint forms, IMR application forms, and instructions online.

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