Healthplex®

Leadership in Dental Plans

MEMBER GRIEVANCE RECORD

Name of Member ______________________ Social Security No/ID# ________________

Address ______________________________ Telephone # ______________________

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Employer/Fund and Group # ____

Group Contact ___________________________________ Telephone # __________

Name of Patient _________________________________ Birth Date ____________

Provider Name __________________________________ Telephone # __________

Address _____________________________________ Claim # (if applicable) ________

____

Treatment Date(s) _____________________ Service(s) Provided ________________

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Nature of Complaint (Be specific) ____

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Member's Signature **Date**

You may also include **copies** of documents you believe pertinent to your complaint.

Please return this form by mail to:

Healthplex, Inc.
60 Charles Lindbergh Boulevard
Uniondale, NY 11553-3608
ATT: Grievance & Appeals Department

or by fax to:

(516) 228-9569/68

You will be contacted in writing within **15 days** of our receipt of your complaint.

We regret any inconvenience you may have experienced. Thank you for bringing your concerns to our attention.