GRIEVANCE FORM

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

The CDI Group, Inc.
P.O. Box 163990
Austin, TX 78716-3990
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 CDI by telephone at (877) 545-4188, or you can complete a Grievance Form online at your respective plan's website. Please see your DOS/DF for your plan's website or call (877) 545-4188 for directions.

California law requires CDI 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 **1-877-545-4188** 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 (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

Please complete the following questionnaire in full, writing as legibly as you can:

1. Full Name of Grievant (including middle initial):

   _____

2. If the Grievant is a dependent of the Subscriber (i.e., the person who enrolled in the plan as the primary member), the full name of the Subscriber (including middle initial):

   _____

3. Subscriber Number: _____

4. Grievant's Address and Telephone Number:

   _____

   _____

   _____

5. If this grievance has been prepared by someone other than the Grievant, please state:

   _____ (full name of preparer)

   _____ (relationship to Grievant)

   _____ (preparer telephone #)

6. Name of the Grievant's Network Dentist

   _____

7. Address of Grievant's Network Dentist

   _____

   _____

   _____

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.