Healthplex®

Leadership in Dental Plans

# MEMBER GRIEVANCE RECORD

Name of Member _____ Social Security No/ID#_____

Address _____ Telephone #_____

_____

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 _____

_____

Nature of Complaint (Be specific) _____

_____

_____

_____

_____

**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.