FIRST COMMONWEALTH
A Wholly Owned Subsidiary of Guardian

Grievance Form

This form has been provided for you in response to your request to enter a grievance about some aspect of care or service in your First Commonwealth dental benefit plan. Please return this form to: First Commonwealth / Quality Care Liaison / P.O. Box 4391 / Woodland Hills, CA 91365-4391

Please Print all Information Below:

Member ID Number	Subscriber Name	Group Number

Address	Home Phone
City, State, Zip	Work Phone

Name and provider number of the dental office involved

This grievance relates to: ☐ Subscriber ☐ Dependent Name_____

Please explain your grievance.

Have you discussed this with your dentist? What was the result of that discussion?

What action would you like First Commonwealth to take?

Our affiliated dentists and corporate staff are committed to prompt resolution of all grievances.
If your inquiry was not satisfied at the time of your call to our member services unit, additional time may be required to collect records, x-rays, bills, receipts, and any other pertinent documentation. **Please submit any and all information, including bills, receipts, x-rays, etc., that you believe will support your grievance. This information will enable us to document and address your concerns.** Upon receipt of that information, you will be notified regarding our next steps or any additional information we require. You will receive a resolution, in writing, after we have reviewed all materials. If you do not agree with that resolution, you may submit a written appeal of the decision within thirty days.

Member (or Legal Guardian) Signature:	Date:

FIRST COMMONWEALTH
A Wholly Owned Subsidiary of Guardian

To: Dental Office: _____
Address: _____
City: _____
State: _____

RE: **AUTHORIZATION TO RELEASE INFORMATION**

You are hereby authorized to release to First Commonwealth, Inc. ("FCW") and its representatives any and all information you may have concerning my dental condition, including x-rays, which you have obtained as a result of history, examination, testing, diagnosis, treatment recommendations and/or treatment.

FCW requires this information for the purpose of resolving my written grievance.

This Authorization shall remain valid for one year from today's date. A signed copy of this Authorization is as valid as the original.

I realize that I am entitled to have a copy of this signed Authorization and if one is requested, do acknowledge receipt thereof.

Select ONE of the following options:

[ ] FCW **MAY** provide the dentist(s) that is/are subject of this grievance a copy of my written grievance.

[ ] FCW **MAY NOT** provide the dentist(s) that is/are subject of this grievance a copy of my written grievance.

If no choice is indicated, FCW will understand that authorization to release a copy of this grievance is approved.

I have read this Authorization before signing it.

_____ _____
Signature Type or Print Name

_____ _____
Member ID Number Date

If not signed by the patient, please indicate relationship:

[ ] Parent or guardian of minor patient
[ ] Guardian or conservator of incompetent patient
[ ] Beneficiary or personal representative of deceased patient
[ ] Spouse or person financially responsible for the patient, where the dental information is being sought for the sole purpose of processing an application for health insurance or for enrollment in a nonprofit hospital plan, a health care service plan, or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan.