

## COMPLAINT FORM

Please complete this Form in full and attach any dental bill and/or itemized receipt. All Complaints must be received within ninety (90) days from the date of service.

PLEASE MAIL TO: DentaQuest Mid-Atlantic, Inc.  
c/o Quality Assurance Department  
4061 Powder Mill Road, Suite 325  
Calverton, MD 20705-3149  
Telephone: 301-937-4447  
Toll Free: 1-800-879-0288

### A. SUBSCRIBER INFORMATION

SUBSCRIBER'S NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

WORK PHONE: ( ) \_\_\_\_\_ HOME PHONE: ( ) \_\_\_\_\_

EMPLOYER'S NAME: \_\_\_\_\_ FEE SCHEDULE: \_\_\_\_\_

### B. DENTIST INFORMATION

DENTIST'S NAME: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

DENTIST'S ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

DATE COMPLAINT OCCURRED: \_\_\_\_\_  
(MONTH/DAY/YEAR)

### C. DESCRIBE YOUR COMPLAINT (PLEASE ATTACH ADDITIONAL SHEET IF NECESSARY)

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### D. RESOLUTION DESIRED: \_\_\_\_\_

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HAVE YOU SPOKEN TO THE DENTIST AND/OR THE DENTIST'S STAFF ABOUT THIS MATTER? \_\_\_\_\_

IF SO, PLEASE LIST THEIR NAMES: \_\_\_\_\_

HAVE YOU SPOKEN TO OUR MEMBER SERVICES DEPARTMENT ABOUT THIS MATTER? \_\_\_\_\_

IF SO, PLEASE LIST THEIR NAMES: \_\_\_\_\_

I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. BY SIGNING BELOW, I AUTHORIZE AND GIVE MY PERMISSION TO DENTAQUEST MID-ATLANTIC, INC. TO OBTAIN ANY DENTAL TREATMENT INFORMATION ON MY BEHALF TO INCLUDE DENTAL RECORDS AND X-RAYS AS MAY BE DEEMED NECESSARY BY DENTAQUEST MID-ATLANTIC, INC. IN THE RESEARCH AND RESOLUTION OF MY COMPLAINT. I FURTHER GIVE DENTAQUEST MID-ATLANTIC, INC. PERMISSION TO FORWARD MY COMPLAINT TO THE PARTICIPATING DENTIST IN THE RESEARCH AND RESOLUTION OF MY COMPLAINT.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT PRINT NAME

\_\_\_\_\_  
PARENT/ LEGAL GUARDIAN SIGNATURE (IF MINOR)

\_\_\_\_\_  
PRINT NAME

DATE: \_\_\_\_\_

TO ASSIST MEMBERS IN UNDERSTANDING AND EXERCISING THEIR RIGHTS OF APPEAL, THE MARYLAND HEALTH EDUCATION AND ADVOCACY UNIT WAS CREATED. THEY MAY BE CONTACTED AT:

ADDRESS: HEALTH EDUCATION AND ADVOCACY UNIT  
OFFICE OF THE ATTORNEY GENERAL  
200 ST. PAUL PLACE, 16<sup>TH</sup> FLOOR  
BALTIMORE, MD 21202  
TELEPHONE: TOLL FREE: 1-877-261-8807  
METROPOLITAN BALTIMORE: 410-528-1840  
FAX: 410-576-6571  
E-MAIL: [consumer@oag.state.md.us](mailto:consumer@oag.state.md.us)