

COASTAL DENTAL INC. GRIEVANCE FORM

Name of Grievant: _____

Full Name of Subscriber (if different): _____

GRIEVANT INFORMATION:

Address: _____ City: _____

State: _____ Zip Code: _____

Phone Number: (area code) _____ (tel. no.) _____

If grievance is prepared by someone other than Grievant, state:

Full name of preparer: _____

Relationship to Grievant: _____

Network Provider Information:

Name of Provider: _____

Address of Provider: _____ City: _____

State: _____ Zip Code: _____

Phone Number: (area Code) _____ (tel. no.) _____

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.
