DentaQuest

*Serving the MassHealth Program**

MassHealth

MassHealth Member Dental Complaint Form

PLEASE RETURN FORM TO:
MassHealth Dental Program
Attention: Intervention Services
P.O. Box 9708
Boston, MA 02114-9708

If you have any questions regarding this form or how to complete it, please call Intervention Services at 800-207-5019.

Name of person completing this form: _____

Relationship to Member: _____

Date Problem Occurred: _____

Member Information:

Member's Name: _____

MassHealth ID Number _____

Social Security Number: _____

Address: _____

City:_____

State:_____Zip Code: _____

Phone Number: _____

Provider Information:

Involved Provider's Name: _____

Address: _____

City:_____ State:_____Zip Code: _____

Office Phone Number:_____

Please explain in your own words what occurred (attach additional pages, if necessary):

_____

_____

_____

_____

_____

_____

_____

Please include a copy of any bills or other documents related to your complaint.

Signature: _____ Date: _____

Print Name: _____

MassHealth will acknowledge receipt of the Complaint in writing within ten (10) business days of receiving the Complaint. You will receive a resolution, in writing within thirty (30) days of the date MassHealth first received your Complaint.

** DentaQuest, LLC is the subcontractor to Dental Service of Massachusetts, Inc.*