DELTA DENTAL

When complete mail to:
Guarantee Of Service Excellence[sm] Program
Northeast Delta Dental
P.O. Box 2002
Concord, NH 03302-2002

Guarantee Of Service Excellence[sm] Program Refund Request

Date: ________________ Group Name: ________________________________

Group Address: ____

City: __________________ State: ______Zip: ______________ Group/Sub #: __ __ __ __ - __ __ __ __

Group Representative Requesting Refund: ________________________________

Title of Group Representative: ______________________ Telephone #: (_ _ _) - _ _ _ - _ _ _ _

Name of Subscriber (if applicable): ________________________________

Name of Dentist (if applicable): ____________________ Dentist City/Town: ______________

Nature of Problem (please check below)

❶ **Smooth Implementation to Northeast Delta Dental**
[ ] Did not successfully meet the criteria for smooth implementation.

❷ **Exceptional Customer Service**
[ ] Did not resolve a telephone inquiry immediately or provide an update within one business day.

❸ **Quick Processing of Claims**
[ ] Less than 90% of a group's accurately completed claim forms processed correctly within 15 days.

❹ **No Inappropriate Billing by Participating Dentists**
[ ] Patient charged for more than the appropriate co-payment at the time of service or for any difference between a participating dentist's submitted fee and Delta Dental's approved amount (attach copy of bill).

❺ **Accurate and Quick Turnaround of Identification Cards**
[ ] Not mailed within 15 calendar days.
[ ] Not accurate.

❻ **Timely Employee Booklets**
[ ] Not mailed within 15 calendar days of request, finalized benefits change, or receipt of signed contract.

❼ **Marketing Service Contacts**
[ ] Group did not receive at least two Marketing service contacts during a contract term.

Briefly describe below the problem and attach appropriate supporting information including names and dates.

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____ Your Initials: ______________

Refund checks will be mailed to your group address as specified above.
Thank you for making it possible for us to serve you better.

For Delta Dental Use Only

Check #: ______________ Check Date: ____________ GL#: 725.7876.01 Code: ________Guar #: _______
Refund Approved By: ______________________ Date Approved: __________Amount Paid: __________
Letter Signed By: ____

Form # GRRF_0107