REQUEST FOR REVIEW OF DENTAL SERVICES

This form will give the Peer Review Committee necessary background information. Without it the review cannot be conducted. While a refund of the charges you have paid is one of the options that may be recommended by the Peer Review Committee, **a request for a refund should not be made on this form (or in writing)**.

(Please Type or Print)

Patient's Name; Please include title (Mr., Ms., Dr., etc.)

____

Parent/Guardian if patient is less than 18 years old:

____

Address____

City__________________ State ______ Zip__________

Phone: Home______________ Work________________

Dentist's Name___________________________________

Address____

City_________________ State ________ Zip__________

Office Phone_____________________________________

Date treatment started_____________________________

Date treatment completed__________________________

Date last seen by this dentist________________________

When was the problem first recognized?____

Have you discussed the problem with the dentist? Yes _____ No _____ Date(s) of Discussion________________________

Did the dentist respond? Yes ______ No ______ If yes, describe action taken ____________________________________

____

Have you been examined/treated by another dentist(s) for this problem? Yes ______ No ______

If yes, please list name, address and phone number of other dentist(s):

____

Have you asked for help from any other person, organization or agency? Yes _______ No ______

If yes, who?____

Did insurance pay for any portion of this treatment? Yes ______ No ______

Name of Insurance Company _________________________________Policy # ____________________________________

Have you taken any legal action concerning this dispute? Yes ______ No ______

If yes, please describe the action you have taken and the outcome of this action.______________________________________

____

(see reverse side)

Please **briefly** describe your complaint and attach any documentation. DO NOT list any remedy that you are seeking as a conclusion to your complaint as this will be discussed with the appointed mediator. For example, do not indicate that you are seeking a refund of fees or are seeking a monetary settlement. If a remedy is listed the complaint will be returned.

In order that a complete review be performed, I authorize the release to the Peer Review Committee any dental records or information by anyone who has examined me previously. I further agree for the Committee to perform a clinical examination if necessary.

Signature ______________________________ Date Submitted ______________________

RETURN TO: Committee on Peer Review
Alabama Dental Association
836 Washington Avenue
Montgomery, Alabama 36104