PATIENT REQUEST FOR MEDIATION

Upon receipt of this completed form, a mediator will be assigned and will contact you within 10 days to discuss your request and help resolve your complaint. A refund of the charges you have paid is an option to resolving your complaint. However, the maximum amount that could be reimbursed to you is the maximum amount that you paid. Satisfying a request from a patient for settlement or compensation for damages or pain and suffering is not within the scope of peer review.

Patient Information

Date____/____/____ Case #_____

Name_____ Phone(__)_____
Please print or type

Address_____

City_____ State_____ Zip Code_____

Name of Dentist

Name_____ Phone(__)_____

Address_____

City_____ State_____ Zip Code_____

Date of Last Appointment_____/_____/_____

What contact have you made with the dentist to solve the problem(s)?

_____

_____

Please describe the problem(s) specific to the dental treatment received:

_____

_____

_____

_____

_____

_____

Please complete reverse side

Are you in the process of using the court system to resolve your complaint?
____ Yes _____No If yes, please give details:

_____

_____

(Note: Peer Review is an option instead of using the court system.)

! Do you have dental insurance now? Yes____No____

! Did your insurance pay for any portion of this treatment? Yes____No____

If yes, give amount $_____
Insurance Company Name _____
Address_____
Insured Person_____
SSN_____
Group I.D. #_____
Insured's Employer_____

! Has the insurance company been notified of this matter? Yes____No____

(Note: If your case is decided in your favor, the maximum amount of money that could be refunded to you is the maximum amount you paid. The amount paid by your insurance would be returned to your insurance company.)

Thank you for addressing your concerns to the South Dakota Dental Association.

Please provide below a telephone number and the best time of day when the mediator will be able to contact you. If you have any questions in the meantime, please do not hesitate to contact the South Dakota Dental Association, 605/224-9133.

Day Phone (___)_____ Time:_____

Night Phone (___)_____ Time:_____

In order that a complete review be performed, I authorize the release to this committee of any dental records or information by anyone who has examined me previously. I further give my permission for the committee to perform a clinical examination, if necessary.

_____

SIGNATURE

Please return this completed form to:
Executive Director, South Dakota Dental Association, PO Box 1194, Pierre, SD 57501