

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. _____
