D-2a
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 the issue. While a refund of the charges you have paid is one of the options that may be recommended by the mediator, a request of a refund or monetary award should not be made in writing or on this form.

Patient Information:

Date _____ Case # _____

Name _____

Address _____ City _____ State _____ Zip_____

Please provide below a phone number and the best time of day for the mediator will be able to contact you.

_____ _____
Day Phone Time

_____ _____
Night Phone Time

Payment Information:

Amount paid by the patient, parent(s) or guardians relative to the work in question _____
(If parents made separate payments, please who paid how much)

Amount paid by primary insurance relative to the work in question _____

Primary insurance company name_____ Account # _____

Amount paid by secondary insurance relative to the work in question _____

Secondary insurance company name_____ Account # _____

Amount paid by any other party relative to the work in question _____

Name _____ Relationship to the patient _____

Dentist Information:

Name _____ Phone # _____

Address _____ City _____ State _____ Zip_____

Date of last appointment _____

Please describe the problem(s) specific to the dental treatment received (use additional sheets if necessary):

_____

_____

_____

Thank you for addressing your concerns to the _____ Dental Society.

Please sign below under the statement that best applies to your situation:

Signature of Patient (if the patient is 18 years old or over)

I certify that all of the information provided above is true, accurate and complete. 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. I further certify that no portion of the fees for the services which are at issue in this proceeding have been paid for by individuals other than the initiator(s) of this complaint and the third party payer(s), if any, listed above. I hereby consent to notification of the third party payer of this proceeding, and the results of this proceeding, and acknowledge that any monetary award which is recommended by the local peer review committee will be prorated among the parties who paid for the services which are the subject of this proceeding in direct proportion to the percentage of the fee which was paid by the parties.

_____

Signature

Signature of Parent or Legal Guardian – Both Parents are Required to Sign (if the patient is a minor or incompetent)

I certify that all of the information provided above is true, accurate and complete. In order that a complete review be performed, I, as parent or legal guardian of the patient, authorize the release to this committee of any dental records or information by anyone who has examined the patient previously. I, as parent or legal guardian of the patient, further give permission for the committee to perform a clinical examination if necessary. I further certify that no portion of the fees for the services which are at issue in this proceeding have been paid for by individuals other than the initiator(s) of this complaint and the third party payer(s), if any, listed above. I hereby consent to notification of the third party payer of this proceeding, and the results of this proceeding, and acknowledge that any monetary award which is recommended by the local peer review committee will be prorated among the parties who paid for the services which are the subject of this proceeding in direct proportion to the percentage of the fee which was paid by the parties.

If applicable, please indicate who is the custodial parent or legal guardian of the patient.

_____ _____

Signature Address City State Zip

_____ _____

Signature Address City State Zip

Signature of Parent or Legal Guardian – Required if One Parent Cannot be Located (if the patient is a minor)

I certify that all of the information provided above is true, accurate and complete. In order that a complete review be performed, I, as parent or legal guardian of the patient, authorize the release to this committee of any dental records or information by anyone who has examined the patient previously. I, as parent or legal guardian of the patient, further give permission for the committee to perform a clinical examination if necessary. I hereby certify that I have legal custody of the patient who is a minor and none of the cost of the treatment which is the subject of this peer review proceeding has been paid by the minor child's noncustodial parent, and that the address, phone number, or other information relative to the present residence or employment of the child's noncustodial parent is unknown to me and not reasonably ascertainable. I further certify that no portion of the fees for the services which are at issue in this proceeding have been paid for by individuals other than the initiator(s) of this complaint and the third party payer(s), if any, listed above. I hereby consent to notification of the third party payer of this proceeding, and the results of this proceeding, and acknowledge that any monetary award which is recommended by the local peer review committee will be prorated among the parties who paid for the services which are the subject of this proceeding in direct proportion to the percentage of the fee which was paid by the parties.

_____ _____

Signature Address City State Zip

Please print this form, and mail to: Dr. William Nelson - Peer Review Chairman
7575 Fredle Dr. Ste #101
Concord, OH 44077