Amended 1/23/17

Colorado Dental Association's Peer Review

Request for Review of Dental Services

CDA Case # _____ (CDA Use)

This form will give the Colorado Dental Association's Peer Review committees necessary background information. Without this form properly completed, a review cannot be conducted. The more clearly and concisely you describe the situation or problem, the more effective the review committee can be. **(PLEASE TYPE OR PRINT CLEARLY.)**

HAVE YOU FILED A LAWSUIT REGARDING THIS MATTER? _____
HAVE YOU FILED A COMPLAINT WITH THE STATE BOARD OF DENTAL EXAMINERS REGARDING THIS MATTER? _____

Name of person requesting review: _____ Phone: (___) _____

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____
City State Zip

Home Phone: (___) _____ Work Phone: (___) _____

email address: _____ I authorize the CDA Peer Review Committee to email me regarding this case Yes ___ No ___

Parent or Guardian: _____
(If patient is under 18 years old) (Relationship to patient)

_____ Office Phone: (___) _____

Name of Dentist: _____

Address: _____
City State Zip

Date treatment started: _____ Date treatment completed: _____

Date last seen by dentist: _____

Date problem first recognized: _____

Have you discussed concern with dentist? ____ Yes ____ No If yes, what dates: _____

Did dentist respond? ____ Yes ____ No

If yes, what action was taken? _____

_____

_____

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

If yes, please list name and telephone numbers of the other dentist(s):

Dentist(s) Name: _____ Office Phone: (___) _____

Dentist(s) Name: _____ Office Phone: (___) _____

Dentist(s) Name: _____ Office Phone: (___) _____

Have you asked for assistance from another person, organization or agency? ____ Yes ____ No
If yes, please list name, address, telephone numbers, and contact person at each organization:

_____

_____

_____

Please briefly describe your concerns and the events that occurred in this dental treatment situation. If you need more space, please attach additional page(s).

_____

_____

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_____

_____

What can Peer Review do to help remedy your concerns?

_____

_____

_____

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_____

While a refund of any charges you may have paid is one of the options that may be recommended by the mediator, a request for a refund should not be made in writing on this form. Peer Review is not a court and has no disciplinary function regarding a dentist's license. It merely provides an alternative dispute resolution mechanism, at no cost to either party. In the event a dentist is directed to refund money to a patient, the maximum amount allowed CANNOT exceed the fees paid. There are no provisions in Peer Review to grant patients money to cover additional dental work or to compensate them for pain, suffering, inconvenience, etc.

The Peer Review process will begin upon receipt of this form, provided it is complete, accurate and correctly filled out.

In order that a complete review be performed, I authorize the release to the CDA Council on Peer Review or its designated component Peer Review committee any dental records or information by anyone who has examined me relevant to this matter. I also give my permission for a clinical examination if deemed necessary by the designated Peer Review committee.

I attest that all statements made by me in relation to this request are true to the best of my knowledge and belief.

_____ _____

Authorized Signature Date Submitted

Return to: CDA Council on Peer Review

8301 E. Prentice Ave., Suite 400 Greenwood Village, CO 80111-2906

PLEASE MARK ENVELOPE - "PERSONAL AND CONFIDENTIAL