Illinois State Dental Society Request for Review of Dental Services Form

Instructions to Complete the Request for Review of Dental Services Form

The Illinois State Dental Society's mediation and clinical peer review process can assist in reviewing disputes between patient and dentist. The disputed issues must be clinical and have occurred in the last two years. This means that the dispute is about the appropriateness or the quality of the dental care that has been provided by the dentist.

The mediation and clinical peer review process is not a court and has no disciplinary function. It merely provides an alternative dispute mechanism, at no cost to either party.

The process **cannot** review office billing or fee disputes or any issue that deals with the business aspects of operating a dental practice. The Mediation and Clinical Peer Review Committee also will not review cases where there is a difference of opinion between two dentists if no actual services have been provided. The process is **not designed to compensate for pain and suffering.**

If ISDS decides that your complaint is appropriate for review, it will be sent to a local dentist who will attempt to mediate your dispute by phone between the two parties. A copy of your Request for Review of Dental Services form will also be sent to the treating dentist so that he/she can be prepared to discuss the complaint with the mediator. If mediation is unsuccessful and it is deemed appropriate, your case will then be referred to a three-dentist peer review panel (not including the Mediator), who will review your complaint and make a recommendation. It must be noted that the recommendation of the Clinical Peer Review Committee is confidential and is not binding on either party. Each party retains his or her full legal remedies. It is the experience of ISDS, however, that the recommendations of the three-dentist panel are accepted by both parties.

Please make sure that:

- **You DO NOT list a specific remedy you are seeking to resolve the case.**
- You have listed the specific name of the dentist that provided the care and not the name of the dental office.
- The dispute was not or is currently not part of a lawsuit.
- You have provided a full description of the events that occurred.
- All documents that you believe are important are included with the form.
- Refrain from posting disparaging remarks on social media.
- You have signed and dated the form.
- You **DO NOT** Fax or email your complaint.
- **You return the form by U.S. Mail to:** Illinois State Dental Society
Committee on Mediations and Clinical Peer Review
3100 Montvale Drive
Springfield, IL 62704

Request for Review of Dental Services

Return by U.S. Mail to: Illinois State Dental Society
Committee on Mediation and Clinical Peer Review
3100 Montvale Drive
Springfield, IL 62704

(Please Type or Print Clearly in Black Ink)

Patient's Name:_______________________________

Address:_______________________________

City:______________State:________Zip:__________

Day Phone:_______________________________

Evening Phone:_______________________________

Parent/guardian if patient is less than 18 yrs. old:

Name:_______________________________

Address:_______________________________

City:______________State:________Zip:__________

Dentist's First and Last Name:_______________________________

Address:_______________________________

City:______________State:________Zip:__________

Office Phone:_______________________________

Date treatment started:_______________________________

Date treatment completed:_______________________________

Date last treated by this dentist:_

When did you first recognize there was a problem with the clinical treatment?_______________________________

____

Have you discussed it with the dentist? Yes _____ No _____

If yes, what dates:_______________________________

Did the dentist respond? Yes _____ No _____

If yes, what action was 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)_______________________________

____

____

Has a lawsuit ever been filed involving this case? Yes _____ No _____

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

If yes, who?_______________________________

Did insurance or Medicaid pay for any portion of this treatment? Yes _____ No _____

Name of Insurance Company____________________Insured's Employer________________Plan #______________

Name of Medicaid Plan (if you don't know indicate with N/A)_______________________________

Please provide a full written description of the clinical dispute

I give permission for the committee to perform a limited clinical examination if it is deemed necessary by the committee to make a recommendation in this complaint

Date Submitted:______________________________

Signature:___________________________________(this cannot be typed, must be signed in person)
(patient, parent or guardian)

HIPAA VALID AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Patient: Name__________________Phone # (_)________________________
Address____
City____________________________State__________Zip ____________

Dentist: Name__________________Phone # (_)________________________
Address____
City____________________________State__________Zip ____________

I,_______________, am requesting mediation, peer review and/or peer review appeal relating to treatment provided to Patient by Dentist.

On this date:_______________, I hereby authorize Dentist and all other dental and medical sources to use and disclose any and all records or information about Patient's dental and medical history, condition, and treatment, including but not limited to Patient's complete health record, and payment for treatment (collectively, "My Health Information"), in any form or format, including but not limited to hard copy, electronic and oral information, radiographs, and photographs, that may be relevant to treatment provided to Patient by Dentist, to the Illinois State Dental Society and their employees and volunteers, including any appointed mediator, peer review committee members, specialty panel members, and any other individuals whose review of the authorized information is necessary or appropriate to the mediation, peer review, and/or peer review appeal process.

I hereby authorize _______________ to discuss this issue with the Mediator to further discuss and resolve this issue.

Purpose for Disclosure: At the request of the individual, for purposes of mediation, peer review, and any peer review appeal.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Signature:______________________________________(this cannot be typed, it must be signed in person)
(patient, parent or guardian)