

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.

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. 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 that 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.
- both parties currently reside in the state of Illinois.
- you have signed and dated the form.
- you are returning the form to:

Illinois State Dental Society
Committee on Mediation and Clinical Peer Review
P.O. Box 376
Springfield, IL 62705

REQUEST FOR REVIEW OF DENTAL SERVICES

RETURN TO: Illinois State Dental Society
Committee on Mediation and Clinical Peer Review
P.O. Box 376
Springfield, IL 62705

(REVISED November, 2004)

(Please Type or Print Clearly in Black Ink)

Patient's Name				Dentist's Name			
Address				Address			
City	State	Zip		City	State	Zip	
Home Phone	Work			Office Phone			
Parent/Guardian if patient is less than 18 years old				Date treatment started			
Name				Date treatment completed			
Address				Date last seen by this dentist			
City	Zip			Do you know if this dentist is a specialist?	Yes	No	
Home Phone	Work			If yes, what specialty?			

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 pay for any portion of this treatment? Yes No

Name of Insurance Company

Name of Insured's Employer

Policy #

