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).

____

____

____

____

____

What can Peer Review do to help remedy your concerns?

____

____

____

____

____

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

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 me 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 my dental and medical history, condition, and treatment, including but not limited to my 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 me by Dentist, to the ***Metro Denver Dental Society and the Colorado Dental Association*** 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.

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.

I understand that I may revoke this authorization at any time by sending written notice to:

Metro Denver Dental Society
925 Lincoln Street, Unit B
Denver, CO 80203
and

Colorado Dental Association,
8301 E. Prentice Ave, Suite 400
Greenwood Village, CO 80111

I understand that this authorization remains effective until Dentist or other dental or medical source is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed. I understand that any revocation will not affect any use or disclosure permitted by the authorization while it was in effect, and that information about my right to revoke may also be in the Notice of Privacy Practices of Dentist or other dental or medical source.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits. However, if I refuse to sign or revoke this authorization, I may not be able to participate in mediation, peer review, and/or appeal.

I hereby release, hold harmless, and agree to indemnify Dentist, any other dental or medical source that I have hereby authorized to use or disclose my Health Information, ***Metro Denver Dental Society and the Colorado Dental Association,*** and their employees, members, volunteers, contractors, and agents, for any and all legal responsibility or liability (including but not limited to negligence) arising out of or occurring under this authorization and the use and/or disclosure of information to the extent indicated and authorized herein.

A copy of this signed, dated Authorization shall be effective as the original.

I understand that I may refuse to sign this authorization. I have been given an opportunity to ask questions, and I have received a copy of the signed authorization.

Signature of patient or patient's personal representative:

____

Date: _____________________

If personal representative – Print Name: ________________________________

Relationship to Patient: ____

____
For office use only: Copy of signed authorization provided to the individual:
Date:____________________Initials: ___________________