Colorado Dental Association's Peer Review

Request for Review of Dental Services

CDA File # _____ (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 or a complaint with the State Board of Dental Examiners regarding this matter?_____
If so this does NOT fall under the scope of Peer Review.

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

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____
City State Zip

Telephone: Home (___) _____ Work: (___) _____

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

Name of Dentist: _____ Telephone: Office: (___) _____

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?: _____

_____

_____

Total fees charged: _____ Total amount paid by patient: _____

Total amount paid by primary insurance company: $_____ Paid to DDS: _____ to Patient: _____

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 Telephone (___) _____

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

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

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. If you need more space, please continue on additional page(s).

_____
_____
_____
_____
_____
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_____
_____
_____
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_____

What can peer review do to help remedy your concerns?

_____
_____
_____
_____
_____
_____

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 CAN NOT 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 East Prentice Avenue Suite 400
Greenwood Village, CO 80111

PLEASE MARK – 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: _____