Request for Mediation Form

Date: _____ Case # _____ ***(To be assigned by NJDA)***

After review of your request and receipt of related documentation, a mediator will be assigned and will contact you to discuss your concerns and help resolve the issue. While a refund of the charges you 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 or on this form.

PATIENT INFORMATION

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

DENTIST INFORMATION

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone : _____ Date of Last Appointment: _____

Please describe the problem(s) specific to the dental treatment received:

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Thank you for addressing your concerns to the New Jersey Dental Association. Below, please provide a phone number and the best time of day for the mediator to contact you. If you have any questions, please call the NJDA at 732-821-9400.

Day Phone: _____ Time of Day: _____

Evening Phone: _____ Time of Evening: _____

In order that a complete review be performed, I authorize the release, to this committee, of any dental records or information by anyone who has examined me previously. I further give my permission for the committee to perform a clinical examination if necessary. I understand that the committee's examination, if performed, will be limited to an evaluation of the treatment in question and does not constitute a complete dental examination.

Signature: _____ Date: _____

Fax to: 732-821-1082 Attention: Peer Review Program