REQUEST FOR REVIEW FORM

This form will give the PESC Administrators Peer Review Committee important background information on your case. Briefly describe your problem (be specific and include everything you can remember about dates, places, names). If you need more space, use additional sheets and attach them to this form when you return it to PESC Administrators. If possible include a copy of the dentist's bill.

Please type or print clearly in ink.

This form will be returned if the Peer Review Committee cannot read it.

PATIENT INFORMATION

Patient's Name: ____

Address: ____

City:____ State:______ Zip:_____________

Work phone: ______________________

Home phone:______________________

Parent/guardian name *(if patient is less than 18 years old)*: _____________________________

Parent/guardian address: ____

Parent/guardian city:_________________________________ State:______ Zip:____________

Parent/guardian work phone: ______________________

Parent/guardian home phone: ______________________

DENTIST INFORMATION

Dentist's Name: ____

Address: ____

City:____ Sate:______ Zip:______________

Work phone:___________________________

Date treatment started: ___________________

Date treatment completed: ________________

Date last seen by this dentist:_______________

Date you first felt there was a problem:____

Do you know if this dentist is a specialist?

_____ No

_____ Yes - indicate specialty:____________________________________

Have you tried to settle this matter with the dentist?

_____ No

_____ Yes - on which dates: _____________________________________

Did the dentist respond?

_____ No

_____ Yes - what action did the dentist take?:

Have you been examined or treated by another dentist (s) for this problem?

_____ No

_____ Yes - give name, address and phone:

Second dentist's name: ____

Second dentist's address: ____

Second dentist's phone: ____

Have you asked for help from any person, organization or agency?

_____ No

_____ Yes - give names, dates, and actions being taken:

____

____

Are you aware of any litigation concerning this complaint including small claims court, notice of intent to sue, or if a malpractice suit has been filed?

_____ No

_____ Yes - indicate type of action:

Do you have dental insurance now?

_____ No

_____ Yes -

Name of person insured: _________________________________

Insured's Social Security #: _______________________________

Group I.D. #r: ____

Insured's employer: ______________________________________

Name of insurance company: _______________________________

Insurance company address: ________________________________

Name of patient's insurance company: _____________________________

Did your dental insurance pay any portion of this treatment?

_____ No

_____ Yes - indicate amount: $_________

Has the insurance company been notified of this matter?

_____ Yes

_____ No

How did you become aware of PESC Administrator's Peer Review Process?

____

____

What do you suggest as a fair solution to your problem?

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By my signature below, I acknowledge that PESC Administrator’s peer review process handles only matters relating to appropriateness and/or quality of dental care. Problems about prices charged for dental treatment, reimbursement for lost time from work, or compensation for pain suffered is not and shall not be covered by PESC Administrator's peer review process:

Patient's signature: ______________________________________ Date: __________

Signature of patient's parent/guardian: __________________________ Date: ___________

<u>Please type or print clearly in ink.</u>