MASSACHUSETTS DENTAL SOCIETY

Two Willow Street
Southborough, MA 01745-1027
800.342.8747 • Fax: 508.480.0002
massdental.org

Dear Patient:

Enclosed is the “Request for Peer Review” complaint form, which you requested. Please return this signed form along with the complaint form so that your complaint can be processed appropriately.

Sincerely,

Massachusetts Dental Society Peer Review Committee

Limitations of Peer Review

- I understand that the Peer Review Committee can recommend only a refund or a partial refund of the monies that have been paid if they find in my favor.
- I understand that the Committee cannot recommend that the dentist be asked to pay any additional costs I have incurred or may incur regarding the treatment in question.
- I understand that the Committee cannot recommend that the dentist pay to have the work redone by another dentist
- I understand that I will be required to sign a release in order to receive any refund recommended by the Committee.
- I am willing to participate with the committee in the resolution of my complaint under these guidelines.

NAME _____

_____ _____

SIGNATURE **DATE**

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COMPLAINT FORM
REQUEST FOR PEER REVIEW

Date _____/_____/_____

Case # _____
To be assigned by the Peer Review Committee

Upon receipt of this completed form, a mediator will be assigned who will contact you to discuss your request and attempt to resolve your problem.

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone (_____) _____-_____

Email Address _____

DENTIST INFORMATION *(please provide information on the individual dentist providing treatment)*

Name _____ Phone (_____) _____-_____

Practice Name: _____

Address _____

City _____ State _____ Zip Code _____

Date of Last Appointment _____/_____/_____

RETURN TO

Peer Review Committee
Massachusetts Dental Society
Two Willow Street, Suite 200
Southborough, MA 01745-1027

COMPLAINT Please describe the problem(s) specific to the dental treatment received:
(Please print clearly or attach typed or additional sheets)

With this complaint, I am requesting: *(Check all that apply)*

- ☐ Refund to my insurance
- ☐ Refund of out-of-pocket expenses related to this procedure
- ☐ Retreatment
- ☐ Other. Please explain:

To perform a complete review, I authorize the release of any dental records or information by anyone who has examined me previously to the Massachusetts Dental Society Peer Review Committee and its local district peer review committee. I further give my permission for the Committee to perform a clinical examination if necessary.

_____ _____

SIGNATURE **DATE**