Patient Request for Mediation - Montana Dental Association
CONFIDENTIAL

Upon receipt of this completed request, a mediator will be assigned and will contact you within ten (10) days to 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 refund should not be made in writing on this form. Return the completed request to:

Mail: Montana Dental Association, PO Box 1154, Helena, MT 59624
Fax: (406) 443-1546
Email: PDF to info@montanadental.org.

Please call (800) 257-4988 with any questions.

Patient information:

Name: _____ Email:_____

Day Phone: _____ Evening Phone: _____

Address:_____

City: _____State: _____ Zip:_____

Dentist:

Name: _____ Phone: _____

Address:_____

City: _____State: _____ Zip:_____

Date of last appointment:_____

Please attach a description of your concerns specific to the dental treatment received. A copy of this statement will be provided to the treating dentist.

Please read below and sign.

In order for my request for mediation to be performed, I authorize the release to the peer review 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.

Patient's Signature (or parent/guardian, if minor): _____

Date: _____

Rev. 1/8/16