MDS
MASSACHUSETTS DENTAL SOCIETY

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

Complaint Form

REQUEST FOR PEER REVIEW
MASSACHUSETTS DENTAL SOCIETY

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. Although a refund or a partial refund is one of the possible outcomes of this complaint, please do not request a refund on this form.

PATIENT INFORMATION

DATE ____/_____/_____ **Complaint # ____**
(to be assigned by the Peer Review Committee)

NAME ____

ADDRESS ____

CITY _________________________________ STATE __________ ZIP CODE _________

Telephone (Day) ______________________ (Evening) ____________________________

DENTIST INFORMATION (Name of individual dentist who provided treatment in question)

NAME ____ PHONE (_____) _____ - ________

ADDRESS ____

CITY _____________________________________ STATE ______ ZIP CODE ___________

DATE OF LAST APPOINTMENT ______/______/______

Please describe the problem(s) specific to the dental treatment received: (PLEASE TYPE OR PRINT CLEARLY).

Thank you for addressing your concerns to the Massachusetts Dental Society Peer Review Committee.

In order that a complete review can be performed, I authorize the release to the Massachusetts Dental Society Peer Review Committee and its local district 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.

____ _________________________

SIGNATURE **DATE**

Return to:

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

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Southborough, MA 01745-1027
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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,

MDS Peer Review Committee

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.

____________________ ____

date signature