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Thank you for contacting us about the dental treatment or services you received from your dentist. The peer review system has been developed by our dental society and the Texas Dental Association. The purpose of the peer review system is to help solve problems about dental treatment or services that the dentist and the patient have not been able to resolve on their own. A special committee of dentists, known as the peer review committee, volunteer their time to consider questions about the quality and appropriateness of dental care and/or questions regarding fees. Cases may also be submitted for peer review when there is a question regarding an insurance claim. These are the only types of questions that the committee can address and your complaint must fall within certain time limitations. It is not within the scope of the peer review system to award monetary refunds for more than the amount the patient has paid for treatment or to determine sanctions on fee levels within particular practices. Voluntary withdrawal of a complaint by the patient, at any time during the process, closes the case. These cases can not be reopened. Also, if an attorney becomes actively involved (other than as a consultant) or if formal legal action is taken, then the file will be closed.

The review process begins when a written request for peer review is submitted to the Peer Review Committee on the Mediation Request Form. The completed Mediation Request Form should include all necessary information and be accompanied by documentation that would help to clarify or support the circumstances, including the names of other dentists or health care providers who have knowledge of your dental care and/or treatment and may have knowledge of the matters at issue and records from those providers. The chairman of the peer review committee reviews the request for appropriateness and appoints one member of the committee to attempt to mediate the problem after the peer review committee receives a completed Treating Dentist Reply Form from the dentist at issue. If the matter is successfully mediated, then a written report is submitted to the committee chairman and the case is closed. If mediation is not successful, then the chairman is accordingly advised and a peer review panel of at least three members is appointed to review the case.

If you decide you want to avail yourself of our services, then please carefully read the enclosed information sheet about peer review and complete and return the enclosed Mediation Request Form to the address provided above along with copies of any dental or other relevant records and information you may have or are able to obtain. The committee urges you to be concise and limit your written comments to the specific complaints that you the committee to consider. Please do not give personal opinions that cannot be used in making a determination in your case.

If you have any questions regarding completion of the forms, then please do not hesitate to contact me at (210) 732-1264. We look forward to hearing from you soon.

Sincerely,

Dr. Victoria Vickers, D.D.S, Chairman, Peer Review Committee
Enclosure: Mediation Request Form

MEDIATION REQUEST FORM

IMPORTANT: RESPONSES ON THIS FORM MUST BE TYPEWRITTEN OR LEGIBLY PRINTED IN INK.

The purpose of this form is to give the peer review committee necessary information regarding your complaint. The more clearly you can describe the situation or problem, the more effective the peer review process can be.

1. Patient Information

Name of Patient(s): _____

Address/City/State/Zip: _____

Home Phone: _____ Bus. Phone: _____ Cell Phone: _____

Name of Parent/Guardian if Patient is a Minor: _____

Address/City/State/Zip: _____

Home Phone: _____ Bus. Phone: _____ Cell Phone: _____

2. Dentist Information

Name of Dentist: _____

Address/City/State/Zip: _____

Bus. Phone: _____

If the dentist is a specialist, then please state the specialty: _____

If you were referred to the dentist by another dentist or health care provider, then please identify the referral source by name, address, and phone number: _____

Date treatment by dentist began: _____

Date of last treatment by dentist: _____

What was the date you first felt there was a problem: _____

3. Insurance Information

Did you have dental insurance at the time of the treatment at issue? Yes No

If yes, then please state the name of your insurer: _____

If yes, did your insurer pay for any portion of the treatment at issue? Yes No

If yes, please provide the amount(s) paid by your insurer for the treatment: _____

4. Attempts to Resolve Matter(s)

Have you tried to resolve the matter at issue with the Dentist? Yes No

Please describe any attempts to resolve the matter(s) at issue and the date(s) of any such attempt(s). _____

5. Litigation

Is there litigation pending with regard to the matter(s) at issue? Yes No

If yes, then who initiated the litigation: _____

If yes, then does the litigation relate to the collection of fees? Yes No

8. Understanding of Peer Review

I understand that, among other things: (a) peer review handles only matters relating to quality of care, appropriateness of treatment, fees, and/or utilization that are made within a certain period of time; (b) the peer review committee cannot address requests, or require monetary relief, for loss of monies in excess of the amounts actually paid for service(s) and/or treatment at issue (e.g., peer review cannot compensate for loss of monies associated with time off of work or pain and suffering); and (c) cases that are voluntarily withdrawn cannot be reopened. I also understand that if I initiate litigation, then my case with the TDA will be closed.

I further understand that if a dentist is asked to refund money, then the refund will be limited to the monies paid for the care, treatment, or services at issue. I also understand that if a dentist is asked to refund money, then a release must be signed within the time provided in order for the refund to be issued.

9. Release of Records/Consent to Examination

IN ORDER FOR THE PEER REVIEW COMMITTEE TO REVIEW AND CONSIDER THIS COMPLAINT, I AUTHORIZE THE RELEASE OF, AND HEREBY RELEASE, MY DENTAL RECORDS, MEDICAL RECORDS, AND OTHER HEALTH CARE INFORMATION RELEVANT TO THE MATTERS AT ISSUE TO THE PEER REVIEW COMMITTEE, THE MEDIATOR, THE PEER REVIEW PANEL, AND THE TDA COUNCIL ON PEER REVIEW, AS WELL AS ANY OTHER PERSON APPOINTED TO REVIEW AND/OR EXAMINE MY RECORDS IN CONNECTION WITH THE PEER REVIEW PROCESS. I FURTHER CONSENT TO, AND PERMIT, THE PEER REVIEW PANEL AND THE TDA COUNCIL ON PEER REVIEW, INCLUDING AD HOC CONSULTANTS APPOINTED BY THEM, TO PERFORM A CLINICAL EXAMINATION, IF SUCH AN EXAMINATION IS DEEMED NECESSARY BY THE PEER REVIEW PANEL OR THE TDA COUNCIL ON PEER REVIEW, IN THE EVENT OF AN APPEAL. I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING. HOWEVER, IF I REVOKE THIS AUTHORIZATION PRIOR TO THE CONCLUSION OF THE PEER REVIEW PROCESS, THEN I UNDERSTAND THAT ANY CASE OPENED IN CONNECTION WITH THIS COMPLAINT WILL BE CLOSED.

Patient Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____