PATIENTS AND THE PEER REVIEW PROCESS

Since you have expressed an interest in using the peer review process of the Missouri Dental Association to resolve a problem between you and your dentist, the following are guidelines and information that will help you understand the process.

Before filing a formal complaint against the dentist, did you discuss the problem with the dentist involved? Many times problems arise because of a lack of communications between the patient and the dentist. If you have not talked to the dentist about your problem, we strongly urge you to do so before filing your complaint.

If you have discussed the problem with the dentist and have been unable to resolve it, then your next action is to file a formal complaint. The Missouri Dental Association has a Peer Review Committee to mediate the differences between the patient and the dentist in which the patient has not been able to resolve. Frequently, with this process the problem is resolved to the satisfaction of all parties concerned.

The Peer Review Committee is composed of dentists who have volunteered their time to consider questions about the quality and appropriateness of dental care. These dentists charge no fee for their services and conduct an impartial REVIEW of the complaint. They will examine not only your letter of complaint, but also the dentist's records of your treatment. They may speak with you and possibly ask you to meet with the Committee so that they can examine, in person, the treatment provided you.

Following a complete examination of all available information, the Committee will report its findings, conclusions, and recommendations to all parties involved. You will be notified by letter within ten working days of the review.

The Committee cannot make anyone (either patient or dentist) abide by its recommendations. However, because you have expressed interest in using Peer Review and because dentists know the value of the peer review system, the Committee assumes both PARTIES will be cooperative.

To initiate a formal peer review of your complaint, please complete and return to the Association the enclosed Peer Review Request Form along with the Authorization for Release of Confidential Information Form. No action will be taken on your complaint until these forms are returned and signed. If you have additional information that will be of assistance to the Committee, you may also return it with these forms.

If you have any questions regarding the peer review process, please let us know before returning the forms.

MISSOURI DENTAL ASSOCIATION
3340 American Ave, Jefferson City, MO 65109
Peer Review Request Form

(Please type or print legibly)

Date ____________________

Your Name ____

Home phone (______) ________________________ Work Phone (______) _________________

Address ____

City ____ State ______ Zip ____________________

YOUR PROBLEM INVOLVES:

Name ______________________________________ Telephone No. (___) _________________

(Dentist's name)

Address ____

City ____ State ______ Zip ____________________

Date of Last Appointment ____

Have you reported this same complaint to the Missouri Dental Board, Attorney General of the State of Missouri or an Attorney at Law? If yes, to whom and date

____

PLEASE TELL US ABOUT YOUR PROBLEM: PLEASE PRINT OR TYPE

NOTE: A request for a refund **SHOULD NOT** be made in writing or on this form.

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PLEASE COMPLETE BACK SIDE

PLEASE TELL US ABOUT YOUR PROBLEM (CONT'D.)

Thank you for addressing your concerns to the Missouri Dental Association.

If the nature of your complaint is within the procedural guidelines of the Peer Review Committee, your case will be reviewed upon receipt of the above requested information and the Release of Confidential Information Form. While a refund of the charges you have paid is one of the options that may be recommended by the Committee, a request for a refund **SHOULD NOT** be made in writing or on this form. If you have any questions in the meantime, you may call the Missouri Dental Association, (573) 634-3436.

Authorization for Release of Confidential - Medical Information or Individual Access to Information Pursuant to HIPAA, 45 C.F.R. Parts 160 and 164

(This form must be dated and signed)

This will authorize the Missouri Dental Association or any of its representatives to inspect and copy the protected health information (PHI), as set out below, and to mail such information to the Missouri Dental Association executive office.

In order that a complete PEER REVIEW PROCESS be performed, I hereby authorize the release of any of my dental records, including, but not limited to, charts, notes, billing information, X-rays, correspondence or other pertinent information to the MDA Peer Review Committee from any dentist who has examined me previously. In addition, I give my permission for the Committee to perform a clinical examination should it be deemed necessary.

I UNDERSTAND THAT:

1. This request is voluntary on my part.

2. I have a right to revoke this authorization at any time, except to the extent that prior action has been taken in reliance on this authorization. I understand if I want to cancel/revoke this authorization, I must mail, fax or bring a letter in person stating I want to cancel this authorization to the address or fax number noted at the top of this authorization. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. This authorization does not include an authorization for records or health information concerning alcohol/drug abuse, HIV testing, HIV results and/or AIDS information.

4. Unless otherwise revoked, this authorization will expire three (3) years after the date signed.

5. Once the information has been released pursuant to this authorization, it may no longer be protected by federal and/or state law/regulations and may no longer be deemed "confidential". Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA and its implementing regulations.

6. A photocopy of this authorization is as valid as the original.

7. Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that no health care provider can make me sign this authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the federal privacy regulations allow it.

8. I may inspect or copy the information to be used or disclosed, as provided in C.F.R. 164.524. I understand that I have a right to a signed copy of this authorization upon request.

Note: If you are signing on behalf of a patient of whom you are the personal representative, you must attach a copy of your appointment as personal representative. If you are signing otherwise on behalf of the patient, state the basis for your authority to request the records of the patient.

____
Patient Name (Please print or type)

____
Social Security Number (if available)

____
Parent/Guardian Name

____
Address

____
City/State/Zip

____
Telephone Number

____
Signature

____
Date