

PATIENT REQUEST FOR MEDIATION

Upon receipt of this completed form, a mediator will be assigned and will contact you within a reasonable amount of time to discuss your request and 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 a refund should not be made in writing or on this form.**

Patient Information:

Date ____/____/____

Name _____ Phone # () _____

Address _____

City _____ State _____ Zip _____

Dentist Information:

Name _____ Phone # () _____

Address _____

City _____ State _____ Zip _____

Date of Last Appointment ____/____/____

Please Describe the Problem(s) Specific to the Dental Treatment Received:

Please return this form to:

Nebraska Dental Association
Attn: David O'Doherty
3120 "O" Street
Lincoln, NE 68510

