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:

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Please return this form to:

Nebraska Dental Association
Attn: David O'Doherty
7160 South 29th Street, Suite 1
Lincoln, NE 685106