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
7160 South 29th Street, Suite 1
Lincoln, NE 68516