

For Office Use Only

Claim #: \_\_\_\_\_

## Request for Dental Peer Review

Upon Receipt of this completed form, a facilitator will be assigned and will contact you within twenty (20) days to discuss your request and help resolve the issue. While a monetary judgment payment in your favor is one of the options that may be recommended by Peer Review, a request for a refund or monetary award may not be made in writing or submitted on this form. Failure to comply will invalidate your request.

Please send this form to:

CSDA Executive Director's Office  
835 West Queen Street  
Southington, CT 06489

### Patient Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, and Zip Code: \_\_\_\_\_

Phone#: \_\_\_\_\_

### Name of Dentist

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, and Zip Code: \_\_\_\_\_

Phone#: \_\_\_\_\_

Date of Last Appointment: \_\_\_\_\_

### Problem Description

Please describe the problem(s) specific to the dental treatment received:

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