DeCare Dental℠ NETWORKS

Contracting Dentist Agreement

The undersigned, hereinafter referred to as "**Dentist**", applies to become a **Contracting Dentist** with DeCare Dental Networks, LLC (hereinafter "**DDN**"), national network. I do hereby represent and agree as follows: (*terms in boldface type are defined terms as set forth in the **DDN** Uniform Policies and Procedures and Administrative Guide, collectively referred to as "**UPP**"*):

1. **Dentist** is licensed to practice dentistry in the state(s) or territories of the United States identified below:
2. To accept **Dentist's** submitted charge or the amount specified in the **Maximum Schedule of Allowance,** as determined by **DDN**, whichever is lower, as payment in full for **Covered Services,** and not attempt to collect from a **Covered Person** any amount in excess of any applicable deductible, coinsurance and/or co-payment due for **Covered Services** provided to a **Covered Person.**
3. I agree not to bill, charge, collect a deposit from, seek remunerations from, or have any recourse against any member or persons acting on his or her behalf for services provided under this Agreement. This provision applies to, but is not limited to, the following events: (1) nonpayment by DDN, (2) insolvency of DDN, or (3) breach of this Agreement. This provision does not prohibit me from collecting co-payments, coinsurance, deductibles or fees for uncovered services. This provision shall be construed in favor of the member and shall survive the termination of this Agreement for services provided before this Agreement terminates, regardless of the reason for termination. This provision supersedes any contrary oral or written agreement entered in to between me, DDN, the member or persons acting on his or her behalf regarding liability for payment for services provided under this Agreement.
4. **Dentist's** individual utilization and practice patterns will be tracked through the **Utilization Review and Management System** and can be used to determine the **Maximum Schedule of Allowance** applicable to each **Dentist.** The **Maximum Schedule of Allowance** in effect for **Dentist** will be provided by **DDN** upon request. **DDN** will notify dentist in writing of any changes in **UPP** or the **Maximum Schedule of Allowance** at least thirty (30) days prior to the effective date of such change unless state or federal law requires a different notice period.
5. To provide **Dental Services** to **Covered Persons**, without regard to their race, color, creed, religion, sexual orientation, and past or present dental or health history and status, or any other classification protected by law. **Covered Persons** are individual participants enrolled in **Dental Plans** and identified by **DDN's Plan Clients** as eligible **Covered Persons** under the terms of this Agreement.
6. The terms and conditions in this Agreement shall become effective upon approval of **Dentist's** credentials and acceptance by **DDN**.
7. **Dental Services** covered are those specified in the **DDN Plan Client's Dental Plan.**
8. **Dentist** is not an agent or employee of **DDN** or **DDN's Plan Clients** and shall at all times be acting as an independent contractor and neither **DDN** nor **DDN's Plan Clients** shall be liable for any wrongful act on the part of the **Dentist** performing services for **Covered Persons**. **Dentist** is solely responsible for the creation and maintenance of dentist/patient relationships with **Covered Persons** and for all decisions regarding the provision of dental care, including the choice of procedure and equipment.
9. **Dentist** shall be subject to **DDN's UPP**, as adopted and amended from time to time, and any **Covered Services** rendered to **Covered Persons** shall be in accordance with the **UPP**.
10. **Dentist** shall abide by **DDN's UPP** and furnish information necessary to **DDN** or **DDN's Plan Clients** to make determinations of coverage. Subject to confidentiality requirements, **Dentist** shall make such records available to **DDN** or its **Plan Clients** upon request and without charge, to conduct utilization and dental claim review, and for such other purposes as are described in the UPP.
11. This Agreement, which includes any and all amendments and addenda, may be terminated by either party upon ninety (90) days advance written notice to the other party, or if the **Dentist's** utilization is determined by **DDN** to deviate from peers' utilization. This Agreement immediately terminates upon loss of license to practice dentistry in any state in which the **Dentist** practices or for **Dentist's** breach of the Agreement.
12. This Agreement is not assignable without **DDN's** prior written consent.
13. In the event federal or state laws or regulations require any change in this Agreement, **DDN** shall have the right to amend the Agreement by written notice specifying the Amendment and its effective date. Except as otherwise provided for herein, this Agreement may be amended only in writing and approved by **DDN** and **Dentist**.
14. This Agreement, together with the **UPP**, contains all the terms and conditions between **Dentist** and **DDN**, and supersedes all other agreements, express or implied, regarding the subject matter of this Agreement and the **UPP**.

Accepted by Dentist

Dentist's Signature	Dated	( ) - Phone Number	( ) - Fax Number
Printed Name of Dentist		E-mail Address	
State(s) of Licensure	License Number(s)	Specialty	

Please sign and return to DeCare Dental Networks, LLC and retain a copy of this Agreement for your records.

DeCare Dental Networks, LLC To Complete

Accepted: **DeCare Dental Networks, LLC**
By:
Its:

Date:

MEDICARE PROGRAM
PARTICIPATION ADDENDUM TO THE
DECARE DENTAL NETWORKS CONTRACTING DENTIST AGREEMENT

ARTICLE I
DENTIST OBLIGATIONS

1.1 Dentist hereby acknowledges and agrees to provide Covered Services to Covered Persons enrolled in a Medicare program Dental Plan governed by Centers for Medicaid and Medicare Services (CMS). This includes Covered Persons enrolled in a Medicare program where DDN provides the network administration for dental benefits.

1.2 Timely Access to Care. Dentist agrees to provide Covered Services to Covered Persons in a Medicare program with timely access to assure availability, adequacy and continuity of care. Dentist shall comply with procedures established by DDN to monitor the provisions of Covered Services to ensure compliance with CMS standards.

1.3 Cultural Competency. Dentist shall ensure that treatment options (including the option of no treatment) are effectively communicated and that Covered Services are accessible to all Covered Persons, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities.

1.4 Standards of Care. Dentist agrees to provide Covered Services in a manner consistent with professionally recognized standards of care.

1.5 Certification of Accuracy. Dentist shall certify, in writing, the completeness and accuracy of all dental services. Dentist will cooperate with DDN to address any inquires from CMS regarding the accuracy of data submitted by Dentist. Dentist will indemnify DDN for any penalty or fine assessed by CMS against DDN, resulting from proven inaccuracy of data submitted by Dentist.

1.6 Consent to Non-Covered Services. Dentist shall notify Covered Persons when services are not covered under their Dental Plan and obtain the patient's consent, prior to providing such services. Covered Services may be verified by calling the Dental Plan's customer service.

1.7 Continuation of Care-Insolvency. Dentist agrees that in the event of DDN's insolvency, termination of the CMS contract or other cessation of operations, Dentist will continue to provide Covered Services through the period for which premium has been paid for such Covered Persons.

ARTICLE II
ACCESS TO RECORDS

2.1 Inspection of Books/Records. Dentist acknowledges that Health and Human Services department (HHS), the Comptroller General, or their designees have the right to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of Dentist, or its subcontractors or transferees involving transactions related to Medicare Advantage contracts through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR § 422.504(e)(4) or other applicable law, whichever is later. For the purposes specified in this provision, Dentist agrees to make available Dentist's premises, physical facilities and equipment, records relating to Covered Persons enrolled in a Medicare program, and any additional relevant information that CMS may require.

ARTICLE III
COMPLIANCE

3.1 Federal Funds. Dentist acknowledges that payments for Covered Services through a Medicare program Dental Plan are, in whole or part, from Federal funds. Therefore, Dentist and any of its subcontractors are subject to certain laws that are applicable to individuals and entities receiving Federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the

Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 and any other regulations applicable to recipients of Federal Funds.

3.2 Medicare Laws. Dentist agrees to comply, and to require staff to comply, with all applicable Medicare laws, regulations, and CMS instructions. Further, Dentist agrees that any Covered Services provided by Dentist to Covered Persons will be consistent with and will comply with any Medicare Advantage contractual obligations.

3.3 Illegal Remunerations. Both parties specifically represents and warrants that activities to be performed under the Agreement and this Addendum are not considered illegal remunerations (including kickbacks, bribes or rebates) as defined in 42 USCA § 1320(a)-7b.

3.4 Training, Education and Communications. Dentist shall participate in applicable compliance training, education and/or communications as reasonably requested by DDN, including annual completion of CMS's required Fraud, Waste and Abuse training. DDN will provide or make available the "Medicare Advantage and Medicare Part D (Medicare Prescription Drug) Fraud, Waste and Abuse Compliance Training" course.

3.5 Payment Recovery. DDN may seek monetary recovery, notify CMS and/or Medicare Advantage Organization (MAO) or impose administrative sanctions on Dentist for abuse or fraud identified by post payment review.

ARTICLE IV
TERM AND TERMINATION

4.1 Termination for Medicare Exclusion. Dentist acknowledges that the Agreement and this Addendum shall be terminated if Dentist is excluded from participation in Medicare under § 1128A of the Social Security Act or from participation in any other Federal health care program.

ARTICLE V
GENERAL PROVISIONS

5.1 Inconsistencies. In the event of an inconsistency between terms of this Addendum and the terms and conditions as set forth in the Agreement, the terms and conditions of this Addendum shall govern. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

5.2 Interpret According to Medicare Laws. Dentist and DDN intend that the terms of the Agreement and this Addendum as they relate to the provision of Covered Services under a Medicare program shall be interpreted in a manner consistent with applicable requirements under Medicare law.

DeCare Dental℠ NETWORKS

DeCARE DENTAL NETWORKS, LLC - UNIFORM POLICIES & PROCEDURES ("UPP")

SCOPE: DeCare Dental Networks, LLC ("DDN") establishes a Contracting Dentist Agreement with Dentists to provide Dental Services to Plan Client's Covered Persons. DDN maintains contracts with Dentists who meet specified network participation requirements as identified in these policies and procedures.

PURPOSE: These UPPs inform Dentists of the servicing requirements for dental plan administration established by group purchasers, regulatory agencies and Plan Clients and ensure that Dentists are informed regarding the consequences of failing to comply with the Contracting Dentist Agreement and the UPP. This document is part of the Agreement and identifies the Agreement requirements. DDN is not an insurance company. DDN provides Covered Persons, enrolled in a Dental Plan issued or sponsored by DDN's Plan Client(s), access to a network of contracted, licensed Dentists.

DEFINITIONS

Covered Person(s): Any person entitled to receive **Covered Services** under a **Dental Plan(s)** issued, administered or sponsored by **DDN Plan Client.**

Covered Service(s): The **Dental Services** for which payment may be made, consistent with the **Dental Plan**, subject to the exclusions, limitations, coinsurance, deductibles, annual maximums and other terms of the **Dental Plan.**

Dentist(s): A Doctor of Dental Surgery (D.D.S.), or Doctor of Medical Dentistry (D.M.D.) legally authorized to provide **Dental Services** in the State in which the **Dentist** practices and who has available the necessary dental care resources to provide

Covered Services to **Covered Persons** pursuant to this Agreement, and who is either employed or contracted by a **Dentist** who has entered into this Agreement.

Dental Plan(s): The benefit issued, sponsored or administered by **DDN Plan Clients** through which **Covered Persons** receive **Covered Services.**

Dental Services: All services or class of services, supplies, drugs, equipment or education which a licensed Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) is legally authorized to perform or provide in the State(s) in which the **Dentist** practices, consistent with applicable state statutes, rules or regulations.

DDN Allowance: The lesser of the **Contracting Dentist's** charge or **DDN's Maximum Schedule of Allowance** for an individual **Dentist**, and reimbursed to a **Contracting Dentist** by a **Plan Client** for a **Covered Service** under a **Dental Plan.**

Immediate Termination: Immediate Termination of a **Contracting Dentist's Agreement** occurs upon verification by **DDN** of the loss or suspension of a **Dentist's** license to practice dentistry, or for breach of the Agreement.

Contracting Dentist: A **Dentist** who applies to become a **Contracting Dentist** with **DDN** and whose application, credentialing and/or recredentialing is approved and accepted by **DDN.**

Plan Client(s): A client or customer of **DDN** who signs an agreement with **DDN** to use the national **DDN** network of Contracting **Dentists** to provide **Dental Services** to **Covered Persons** enrolled in **Dental Plans.**

Pre-Estimate of Benefits: The "Pre-Estimate of Benefits" or costs is a valuable tool for the **Dentist** and the **Covered Person**. Submitting a **Pre-Estimate of Benefits**, allows the dentist and **Covered Person** to know what benefits are available for the **Covered Person** before beginning treatment. The **Pre-Estimate of Benefits** will outline the **Covered Person's** responsibility to the **Contracting Dentist** for copayments, deductibles and non-covered services. This will assist the **Dentist** and **Covered Person** with any necessary financial arrangements before treatment begins. This process does not pre-authorize the treatment nor determine its dental or medical necessity. The estimated plan payment is based on the **Covered Person's** current eligibility and **Covered Services,** at the time the Pre-Estimate of Benefits is issued. Submission of other claims, changes in **Covered Person's** eligibility, or changes in **Covered Services** may alter final payment.

Maximum Schedule of Allowance: A specific fee determined by **DDN** and used to determine the **DDN Allowance** reimbursed to the **Contracting Dentist** by a **Plan Client** for a **Covered Service** under a **Dental Plan**, and generally codified by reference to ADA CDT codes.

Utilization Review and Management System (URMS): Analytical method and/or clinical review methods used to evaluate **Dentists'** utilization and patterns of practice, based on submitted claims.

Termination: The ending of a **DDN Contracting Dentist** Agreement, which includes any and all amendments and addenda, with a **Dentist** upon ninety (90) days written notice.

REQUIREMENTS FOR DENTISTS CONTRACTING WITH DDN

Any doctor of dentistry, licensed under the laws of any state of the United States or other U.S. jurisdiction, is eligible to become a **Contracting Dentist**.

GENERAL PROVISIONS

A **Contracting Dentist** may be asked to submit and receive a **Pre-Estimate of Benefits** for non-emergency and major restorative, prosthetic, periodontal and orthodontic **Dental Services** and to accept payment from **DDN** or **DDN's Plan Clients** for specific **Dental Services**. A **Contracting Dentist** agrees not to receive or attempt to collect additional compensation from **Covered Persons** that exceeds **DDN's Allowance,** except for the amount of contract deductibles, coinsurance, co-payments, and other stated obligations under the **Covered Person's** coverage as shown on a **Covered Person's** explanation of benefits statement provided by the **Plan Client**. A **Contracting Dentist** agrees to comply with **DDN's Utilization Review and Management System**, as communicated by **DDN** in writing.

INSURANCE

A **Contracting Dentist** shall maintain professional liability and malpractice insurance coverage in the amount of $1,000,000 per incident/$3,000,000 aggregate.

DeCare Dental℠ NETWORKS

DeCARE DENTAL NETWORKS, LLC - UNIFORM POLICIES & PROCEDURES ("UPP")

AMENDMENT OR NOTIFICATION OF CHANGES TO THE UPP
A **Contracting Dentist** agrees that **DDN** may amend the **UPP** or change the level of reimbursement and **Maximum Schedule of Allowance** upon thirty (30) days written notice of the amendment or changes.

USE OF INFORMATION
A **Contracting Dentist** agrees to allow **DDN** to publish the Contracting **Dentist's** name, dental office name, address, phone number, specialty and if any special languages are spoken, in directories published for access by **Covered Persons.**

REIMBURSEMENT
Reimbursement by a **Plan Client** is **DDN's Allowance**, which is the lesser of: (1) the **Contracting Dentist's** charge or (2) the current **Maximum Schedule of Allowance** applicable on the date a claim is received, minus any patient co-payments, coinsurance, and deductibles as provided under the **Dental Plan** of the **Covered Person**.

PAYMENT FOR DENTAL SERVICES RENDERED BY CONTRACTING DENTISTS
When **Dental Services** are rendered to a **Covered Person** by a **Contracting Dentist**, payment of the **Dental Plan's** obligation is determined by the **Covered Person's** Dental Plan coverage in effect on the date **Dental Services** are provided and such payment, if any, is made directly to the **Contracting Dentist**. The patient's only responsibility is for any deductible, coinsurance, co-payment or other specifically stated obligation on the Explanation of Benefits. In the event a payment to a **Contracting Dentist** is later determined to have been made in error, for any reason, the **Dental Plan** may deduct from future payments due **Contracting Dentist** amounts equal to the amount of any payments made in error. Benefits payable under a **Dental Plan** are not assignable, except to a **Contracting Dentist.**

GRIEVANCES
A **Contracting Dentist** shall comply and provide all necessary documentation to resolve **Covered Person's** grievances, complaints and/or inquiries. A **Contracting Dentist** agrees to cooperate in the resolution of all grievances in accordance with applicable state laws and regulations. If any of the **Plan Clients** or **Covered Persons** raise concerns with **DDN** about the quality of care of any **Contracting Dentist, DDN** will review the matter, which review may include direct communication with the **Contracting Dentist. DDN** shall not function as a peer review or quality assurance organization for **Plan Clients** or **Covered Persons.** Where specific evidence or data comes to its attention relating to the quality of care rendered by any **Contracting Dentist**, **DDN** shall make reasonable efforts to assess the quality of care, based on reasonable standards and generally accepted dental practices.

MAINTENANCE OF AND ACCESS TO RECORDS
A **Contracting Dentist** shall maintain adequate medical, financial and administrative records related to **Dental Services** rendered in accordance with all applicable federal laws, including HIPAA, and laws of the state in which the **Contracting Dentist** practices. **DDN** shall have access to such information and records, including claim records, within fourteen (14) days from the date the request is made. In the case of an audit by **DDN**, such access shall be given at the time of the audit. If requested by **DDN,** a **Contracting Dentist** shall provide copies of such records free of charge. Such obligations are not terminated upon termination of this Agreement if access to such records is requested within three (3) years of such termination for commercial business. A patient's consent to provide **DDN** or its **Plan Clients** with requested information, records or copies of records is authorized by the patient's signature on the Attending Dentist Statement claim form. Federal, state and local government(s) and any of their authorized representatives, shall have access to, and **DDN** and the **Contracting Dentist** are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of necessary information to comply with statutes or regulations applicable to **DDN** and **DDN's Plan Clients** or the **Contracting Dentist**.

CONFIDENTIALITY OF RECORDS
DDN and **Contracting Dentist** shall maintain the confidentiality of all patient records in accordance with any applicable state or federal statutes, laws and regulations.

AVAILABILITY OF INFORMATION
A **Contracting Dentist** may obtain specific plan eligibility and coverage information for a patient, (including identification of maximums, limitations and exclusions through direct telephone contact with **Plan Client's** administrator, through its customer service center's toll-free number shown on the **Covered Person's** identification card.

CLAIM SUBMISSIONS
All claims for dental services submitted to **DDN's Plan Clients** for eligible **Covered Persons** should be either submitted electronically in the format required by the Health Insurance and Portability Act (HIPAA) or printed on the standard ADA claim form and mailed to **DDN's Plan Client** dental claims processing address. Services submitted electronically or on the claim form must be submitted using the most current version of the ADA CDT procedure codes.
DDN's Contracting Dentists shall submit claims without charge, promptly and accurately, on forms or through other methods provided, approved or required by **DDN's Plan Client**. A current version of the American Dental Association (ADA) claim form or electronic claim meeting HIPAA standards is to be submitted only upon completion of treatment and must indicate the treatment completion date. Claims should be submitted within sixty (60) days from the date services are completed. Claims not submitted within six (6) months of the service date are not covered.

SAFETY AND HYGIENE
Contracting Dentist must comply with and be responsible for any and all applicable legal requirements related to dental practice safety and hygiene. Infection control is an expense to the **Contracting Dentist** and is an integral part of all dental procedures. A **Contracting Dentist** agrees to include these costs in their fees or charges for **Dental Services**. Payment for **Covered Services** by the **Dental Plan** includes reimbursement to **Contracting Dentist** for costs associated with infection control. Infection control may not be billed separately from other procedures to either the **Covered Person** or the **Dental Plan**.

EMERGENCY SERVICES
A **Contracting Dentist** shall provide or make arrangements for emergency care services for **Covered Persons** twenty-four (24) hours per day, seven (7) days a week. This may be accomplished by having a recorded telephone message or answering service available to inform patients about where and how to seek emergency care after normal business hours.

TERMINATION OF CONTRACTING DENTIST AGREEMENT
DDN or the **Contracting Dentist** may terminate this Agreement, which includes any and all amendments and addenda, upon ninety (90) days written notice to the other party.

CONTINUATION OF CARE
Except when termination occurs due to a loss of license, a **Contracting Dentist**, upon termination of this Agreement, shall continue **Covered Services** to members if provision of a specific treatment is already in progress, to the extent that it is a requirement of applicable state law or regulations. The **Contracting Dentist** agrees to accept terms of payment under this Agreement for only that service until such service is completed.

GOVERNING LAW
This Agreement shall be governed by the laws of the State of Minnesota, subject to any conflict of law rules. In the event that any provision of this Agreement shall be determined to be invalid or unenforceable, the validity or enforceability of the remaining provisions shall not be affected.

DISPUTE RESOLUTION
Any dispute arising out of or in connection with this Agreement shall be resolved exclusively by binding arbitration between the parties, conducted in Minneapolis, Minnesota. Any arbitration award rendered may be enforced in any court of competent jurisdiction.

FRAUD AND ABUSE PREVENTION AND DETECTION
DDN and/or its **Plan Clients** maintain a program to prevent and detect fraud and abuse. All **Contracting Dentists'** claim submissions, patient charts and records are subject to audit and review by **DDN** or its **Plan Clients** upon written request.

UTILIZATION REVIEW AND MANAGEMENT SYSTEM (URMS)
Contracting Dentist and **DDN** recognize that the design and implementation of a utilization review system and management system is necessary for the cost effective delivery of dental care and the financial integrity of dental plans. **Contracting Dentist** agrees to participate in **DDN's Utilization Review and Management System (URMS)** and to strive to practice cost effective dental care consistent with current scientific oral health epidemiological and clinical research and scientifically based clinical knowledge. **Contracting Dentist's** level of reimbursement may be changed by **DDN** based upon utilization and practice patterns of the **Contracting Dentist** as determined from analysis of submitted claims and peer comparison under **URMS.**

In accordance with the laws of specific states the following provisions apply to Contracting Dentists in:

ALASKA

In the event a dispute arises between DDN and Contracting Dentist, a dispute resolution process will be used to resolve outstanding issues, which may include
(A) an initial meeting within ten (10) working days after DDN receives written notice of a dispute or gives written notice to the Contracting Dentist, unless mutually agreed to in writing to follow a different schedule;
(B) within thirty (30) days following the initial meeting, if the dispute is still unresolved, it shall be submitted to mediation, directed by a mediator who is mutually agreeable to DDN and Contracting Dentist.; each party shall bear its proportionate cost of mediation, including mediator fees;
(C) if, after a period of sixty (60) days following commencement of mediation, DDN and Contracting Dentist are still unable to resolve the dispute, either may seek other relief as allowed by law; and
(D) both DDN and Contracting Dentist shall agree to negotiate in good faith in the initial meeting and in mediation. Reference: AK ST §21.07.010(a)(4).

The Contracting Dentist may not be penalized or terminated by DDN because of their advocacy for covered persons in seeking appropriate, dentally necessary dental services. Reference: AK ST § 21.07.010 (5).

COLORADO

Summary Disclosure Form:
(a) Under the terms of the contract you are providing dental services.
(b) This contract will remain in effect unless terminated by either party.
(c) Claims payment services are provided by DeCare Dental Health International, LLC.
(d) Any dispute arising out of or in connection with this Agreement shall be resolved exclusively by binding arbitration between the parties, conducted in Minneapolis, Minnesota. Any arbitration award rendered may be enforced in any court of competent jurisdiction.

The contract between DDN and a Contracting Dentist shall include provisions for continuity of care as specified in this section. Each Plan shall allow Covered Persons to continue receiving care for sixty days from the date a Contracting Dentist is terminated by DDN without cause when proper notice as specified in this section has not been provided to the Covered Person. Reference: CO ST10-16-705 (4) (b).

DDN and Contracting Dentist shall provide at least sixty days written notice to each other before terminating the contract without cause. DDN shall make a good faith effort to provide written notice of termination within fifteen working days after receipt of or issuance of a notice of termination to all covered persons that are patients seen on a regular basis by the provider whose contract is terminating, regardless of whether the termination was for cause or without cause. Within five working days after the date that the Contracting Dentist either gives or receives notice of termination, the Contracting Dentist shall supply DDN with a list of those patients of Contracting

COLORADO (CON'T)

Dentist that are covered by a DDN Plan. Reference: CO ST 10-16- 705(7).

Neither DDN nor Contracting Dentist shall be prohibited from protesting or expressing disagreement with a dental decision, dental policy or dental practice of DDN or the Contracting Dentist. Reference: CO ST 10-16-121(1) (a).

DDN shall not terminate Contracting Dentist's contract because Contracting Dentist expresses disagreement with DDN's decision to deny or limit benefits to a Covered Person or because Contracting Dentist assists the Covered Person to seek reconsideration of DDN's decision or because Contracting Dentist discusses with the Covered Person any proposed treatments or treatment alternatives, whether covered by the Plan or not. Reference: CO ST § 10-16-121 (1) (b).

Contracting Dentist shall not be subjected to financial disincentives based on the number of referrals made, so long as they adhere to DDN's utilization review policies and procedures. Reference: CO ST 10-16-121(1) (d).

ILLINOIS

None of the rights and responsibilities under this agreement can be sold, leased, assigned, assumed or otherwise delegated by either party without the prior written consent of the other party. Assignment will be deemed approved so long as the assignment is in accordance with the terms of the contract and all the terms and conditions of the contract being assigned, including all appendices, policies and fee schedules are followed.
Reference: IL Adm. Code 2051.290(h)

INDIANA

DDN agrees to provide written notice to Contracting Dentist of any amendments to this Agreement at least forty-five (45) days prior to the date such changes are to become effective. Reference: IN ST 27-1-37.1-5.

In accordance with the above paragraph, a Contracting Dentist who receives notice of changes to this Agreement may terminate the Agreement without penalty within fifteen (15) days after receipt of the written notice from DDN. Such termination must be requested by the Contracting Dentist in writing. Reference: IN ST 27-1-37.1-6.

If Contracting Dentist elects to terminate the Agreement with DDN, such termination shall become effective: (1) Ninety (90) days after DDN receives written notice from the Contracting Dentist that they do not approve the amendment; or (2) on an earlier date than specified in item (1), if agreed upon by DDN and the Contracting Dentist. Reference: IN ST 27-1-37.1-7

Except in an emergency, a Contracting Dentist who elects to terminate this Agreement shall notify covered person(s) prior to providing services that the Agreement between DDN and Contracting Dentist has been or will be terminated as of a particular date. Reference: IN ST 27-1-37.1-9.

KENTUCKY

In no event, including but not limited to nonpayment by Plan Client or DDN, insolvency of the Plan Client or DDN, or breach of this agreement, shall Contracting Dentist bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, a covered person to whom dental care services have been provided, or a person acting on behalf of the covered person, for dental care services provided pursuant to this agreement. This does not prohibit Contracting Dentist from collecting co-insurance, deductibles, or co-payments as specifically provided in the evidence of coverage, or fees for uncovered dental care services delivered on a fee-for-service basis. Reference: KY ST §304.17C-060. Dentist shall provide DDN with at least sixty (60) days prior notice of any subcontractor agreements with other dentists to provide services under the terms of this Agreement. Dentist shall provide DDN with a copy of such subcontracting agreement. Reference: KY ST 304.17A-527(1) (e).

MICHIGAN

A Contracting Dentist whose agreement is terminated by DDN shall be provided upon request with a written explanation by DDN of the reasons for the termination. Reference: MI ST 550.53(5).

A Contracting Dentist who has an agreement with DDN for the provision of dental services shall display a notice in a conspicuous place at the entrance of the Contracting Dentist's place of business indicating any dental plans with which they are affiliated. Reference: MI. ST.550.55.

MARYLAND

DDN agrees to notify Contracting Dentist at least ninety (90) days prior to termination of this Agreement, if the termination is for reasons unrelated to fraud, patient abuse, incompetence or loss of licensure status. Reference: MD Insurance §15-112.

NEW HAMPSHIRE

DDN or its Plan Clients will not terminate a Contracting Dentist from DDN's national network for participating in a Covered Person's internal grievance procedure or external review. Reference: NH Rev. Stat. § 420-J-8 (X).

NEW JERSEY

Contracting Dentist agrees that an appointment must be granted to a Covered Person within ten (10) working days of the date the request is made. Contracting Dentist also agrees that treatment for an emergency must be granted to a Covered Person within twenty-four (24) hours of the emergency. Reference: NJADC 11:10-1.5 (c) 2 and (c) 3.

NEW MEXICO

If a Plan Client fails to pay a Contracting Dentist or pay a Covered Person for out of pocket covered expenses within forty-five (45) days after a clean claim has been received by a Plan Client, located in New Mexico, the Plan Client shall be liable for the amount due and unpaid with interest on that amount at the rate of one and one half times the rate established by a bulletin entered by the New Mexico insurance superintendent in January of each calendar year. A clean claim means a manually or electronically submitted claim that contains all the required data elements necessary for

NEW MEXICO (CON'T)

adjudication without the need for additional information from outside the Plan Client's system and contains no deficiency or impropriety, including lack of substantiating documentation currently required by the Plan Client or particular circumstances requiring special treatment that prevents timely payment from being made by the Plan Client.
Reference: Title 13, Chapter 10, Part 13.25 O.

NEW YORK

DDN shall provide written notice of the reasons for termination of the Contracting Dentist and an opportunity for review or hearing, if requested by the Contracting Dentist in writing within thirty (30) days after written notice of termination has been given. Reference: Article 48, NY Statutes, § 4803(b)(1).

A Contracting Dentist may, upon request, receive data maintained by DDN to evaluate the individual Contracting Dentist's performance or practice, based on the scope of services provided. Reference: Article 48, NY Statutes, §4803(6)(d).

NORTH CAROLINA

The Contracting Dentist is responsible to comply with DDN's utilization management programs, credential verification programs, quality management programs and provider sanctions programs. However, none of these duties shall override the professional or ethical responsibility of the Contracting Dentist or interfere with their responsibility to provide information or assistance to their patients.
Reference 11 NC ADC 20.0202(16).

DDN shall notify the Contracting Dentist, in writing, of any duties or obligations under this Agreement prior to any delegation or transfer. Reference: 11 NC ADC 20.0202(19)(b).

DDN shall provide performance feedback reports or information to the provider, if compensation is related to efficiency criteria. Reference: 11 NC ADC 20.0202 (15) (a).

OHIO

A Plan Client, who is a health-insuring corporation, has responsibility for overseeing and monitoring covered Dental Services provided to Covered Persons. A Contracting Dentist will provide necessary information to applicable Plan Clients to meet this statutory responsibility. Reference: Ohio Statute § 1751.13(6).

The provisions required herein shall not require any Contracting Dentist to continue to provide any covered dental services after the occurrence of any of the following:
(a) The end of the thirty-day period following the entry of a liquidation order under Chapter 3903 of the Revised Code;
(b) The end of Covered Person's period of coverage for a contractual prepayment or premium;
(c) The Covered Person obtains equivalent coverage with another Plan or insurer or the Plan Client obtains such coverage for the Covered Person;
(d) The Covered Person or the Plan Client terminates coverage under the contract;
(e) A liquidator affects a transfer of DDN's or Plan Client's

OHIO (CON'T)

obligations under the contract under division (A)(8) of section 3903.21 of the Revised Code. Reference: OH ST § 1751.13(C)(3)(e).

PENNSYLVANIA

This Contracting Dentist Agreement will be immediately terminated if the Contracting Dentist is found to be harming Covered Persons.
Reference: Pa. Statutes Title 31, Part VIII, Chapter 152.104(3)(vi).

SOUTH CAROLINA

Each party to this Contracting Dentist's Agreement is responsible for the legal consequences and costs of his/her own acts or omissions, or both, and is not responsible for the acts or omissions, or both, of the other party. A clause in a Contracting Dentist's agreement to the contrary is unlawful in this state, as a matter of public policy. Reference: SC ST §38-71-1740(A)(1).

VIRGINIA

No Contracting Dentist or agent, trustee or assignee thereof, may maintain any action at law against a Covered Person to collect sums owed by the Plan Client. VA ST §38.2-5905(B)(2).

DDN agrees that its Plan Clients shall pay any claim within forty (40) days of receipt of the claim, unless the claim is determined by DDN's Plan Client(s) to not be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted (ii) the eligibility of the person for coverage, (iii) the responsibility of another carrier for all or part of a claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or)vi) the manner in which services were accessed or provided; or (b) the claim was submitted fraudulently. Contracting Dentist shall be entitled to inspect records of receipt of claims. All interest owed on a claim will be paid without necessity of demand by the Plan Client to the Contracting Dentist. Reference: VA ST 38.2-3407.15.

WASHINGTON

a. Contracting Dentist agrees, that in the event of DDN's Plan Client's insolvency, to continue to provide the services promised in this contract to covered persons of DDN's Plan Client's for the duration of the period for which premiums on behalf of the covered person(s) were paid to DDN or its Plan Clients, or until the covered person's discharge from inpatient facilities, whichever time is greater.
b. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the covered person's dental plan.
c. Contracting Dentist may not bill the covered person(s) for covered services (except for deductibles, copayments or coinsurance) where the Plan Client(s) deny payments because DDN's Contracting Dentist has failed to comply with the terms or conditions of this Agreement.
d. Contracting Dentist further agrees (i) that the provisions listed in items a. through d., of this section, shall survive termination of this contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of DDN's Plan Client(s) covered persons, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Contracting Dentist and covered persons or persons acting on their behalf. Contracting Dentists may not collect or attempt to collect an amount from a covered person knowing that collection to be e. In violation of the Contracting Dentist Agreement. This constitutes a class C felony under RCW 48.80.030(5). Contracting Dentist may request an informal dispute resolution process prior to requesting the formal dispute resolution process. Reference: WA ADC 284-43-322(1).

The receipt date of a claim is the date DDN's Plan Client(s) receive either written or electronic notice of the claim.

If DDN's Plan Client(s) fail to pay claims within the standard established, DDN's Plan Client(s) shall pay interest on undenied and unpaid clean claims according to the laws, rules or regulations of the state in which the Plan Client(s) issued the benefits plan until claim is adjudicated. Interest shall be assessed at the rate specified in the applicable state statute and shall be payable to the amount of the unpaid claim without the necessity of the Contracting Dentist submitting an additional claim. Any interest paid herein shall not be applied to a Covered Person's deductible, copayments, coinsurance or similar obligation of the Covered Person.

A "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Reference: WA ADC 284-43-321.

Further, DDN will require of its Plan Client(s) compliance with the statutes governing prompt payment in the states regulating said Plan Client's dental benefit contracts.

Contracting Dentist may request an informal dispute resolution process prior to requesting the formal dispute resolution process. Reference: WA ADC 284-43-322(1).

CREDENTIALING APPLICATION

This Credentialing Application cannot be processed until it is completed in FULL.
Please maintain a copy of this Credentialing Application for your records.

Credentialing Application is complete when:

- ❑ **The Credentialing Application has been updated in its entirety, signed and dated**
  (NO STAMPED SIGNATURES)
- ❑ **Current Copies** of the following have been **attached**:
  - ✓ **Dental License** (provide copies for EVERY state in which you are licensed)
  - ✓ **Federal** DEA Registration for **EVERY STATE** the DDS is participating in (or documentation DEA is pending)
  - ✓ **American** Board/Specialty Certificate (if applicable)
  - ✓ **Professional Liability Insurance Declaration** Page – showing minimum coverage of $1 million/$3 million, dentist's name, policy #, effective and expiration dates.
    - o **If expiration date** is within weeks of this application, updated documentation must be submitted.
- ❑ **W-9 Form or Taxpayer Identification Number Request**

Please attach a signed contract for network participation:

- ❑ Dentist Participation Agreement

MAIL CREDENTIALING APPLICATION TO:

DeCare Dental Networks
Attn: Credentialing
P.O. Box 1175
Minneapolis, MN 55440-1175

OR

FAX: (651) 994-5130 or toll free (866) 286-8840

QUESTIONS? Call (toll free) (866) 462-1832 x5364

Notice of Applicant's Right

You may review or request the status of your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable State laws. If there are discrepancies in the information received during the credentialing process, you will be notified and allowed an opportunity to correct erroneous information submitted by another party within thirty (30) days of submitting your application. This includes information submitted by an outside primary source, such as Professional Insurance Carrier, State License Board and/or the National Practitioner Data Bank.

Confidentiality Statement

Information gathered as part of the credentialing or re-credentialing process is maintained in a confidential manner and will not be communicated or reproduced. This provision is designed to safeguard information and ensure confidentiality.

DEMOGRAPHICS (Please type or print) **STATE DENTAL LICENSE #:** _____

Name:	_____ Last First MI
Social Security Number:	___ ___ ___ - ___ ___ - ___ ___ ___ ___
Select One:	☐ Owner ☐ Partner ☐ Associate
State Medicare Number:	_____ Medicaid Number: _____
UPIN Number:	_____
Children's Health Insurance Plan (CHIP) #:	_____
Individual NPI:	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Date of Birth:	___ ___ / ___ ___ / ___ ___ ___ ___
Gender:	☐ Male ☐ Female
Do you currently hold a Federal DEA registration?	☐ YES (Submit copy) ☐ NO (Complete statement below) **IF PENDING COMPLETE**: I Dr. _____ will not write prescriptions until I have received my current Federal DEA. Dr. _____ will be writing prescriptions on my behalf until my current Federal DEA has been received. **IF NO DEA COMPLETE:** I, Dr. _____ do not have a DEA because _____ and Dr. _____ will be writing prescriptions on my behalf.
Languages Spoken Fluently:	

GENERAL DENTISTRY EDUCATION

Institution	Grad Date	Degree

SPECIALTY EDUCATION

Institution	Specialty	Grad Date	Degree

For the above **SPECIALTY**, I am:

☐ Educationally Qualified (**showing institution name, grad yr, and specialty**)

☐ **AMERICAN Board Certified *** (attach certificate copy from **American Board**)

* Date of Certification: _____ Expiration Date: _____

PROFESSIONAL LIABILITY INSURANCE FOR EACH ENTITY IN WHICH YOU PRACTICE AT
(Complete information below OR attach copy)

CARRIER:	**POLICY #:**
COVERAGE LIMITS (Occurrence/Aggregate):	
EFFECTIVE DATE:	**EXPIRATION DATE:**

The selection process ensures that Credentialing decisions are not based on an applicant's race, ethnicity/nationality, gender, age, sexual orientation, or the types of patients or procedures in which the dentist specializes

DDS NAME AND STATE DENTAL LICENSE NUMBER (As indicated on your license copy):

_____

PRIMARY PRACTICE LOCATION **If more than one location please attach a separate sheet with the below information.**

Group/Practice Name:	_____
Street Address (Building; Street; Suite #):	_____
City/State/Zip:	_____ County:_____
Office Phone Number:	(_____)_____ ER/After Hours Number: (_____)_____
Fax Number:	(_____)_____ Office Email: _____
Tax ID Number (TIN): AS LISTED ON W-9	____ ____ -- ____ ____ ____ ____ ____ ____ ____
Type 2 NPI:	Clinic: __ __ __ __ __ __ __ __ __ __ Corporate: __ __ __ __ __ __ __ __ __ __
Office Manager/Contact:	_____
	Are office protocols for infection control in compliance with current CDC/OSHA guidelines? ☐ Yes ☐ No

CORRESPONDENCE INFORMATION: (If different from primary practice location) This address is used to send communications such as welcome letters and newsletters		**BILLING INFORMATION:** (if different from primary practice location) This address is for claim reimbursement	
Address:	_____ _____ _____	Address:	_____ _____ _____
Office Manager/Contact:		Office Manager/Contact:	

EMPLOYMENT HISTORY: Chronological listing must include **MONTH and YEAR** for each entry of employment history for the **MOST RECENT 5 years**. List all armed service, public health, education, business or professional activities, sabbatical, etc. LEAVE **NO GAPS** IN CHRONOLOGY.

Dates (Month & Year)	Facility and Address	Phone Number & TIN	Reason for Leaving:
From: ____ / ____ To: **Present**	Current Location		
From: ____ / ____ To: ____ / ____			
From: ____ / ____ To: ____ / ____			

PRIMARY ADMITTING FACILITY (List present hospital/surgical center privileges in chronological order beginning with the most recent.)

Primary Admitting Facility:	_____
Type of Status:	_____
Street Address:	_____
City/State/Zip:	_____
Dates (Month/Year):	From: To:

DISCLOSURE QUESTIONS

Please complete the Professional Liability Addendum if questions 1-10 are answered in the affirmative.

1. ☐ Yes ☐ No **Have you ever** had your **professional license, registration or DEA** terminated, stipulated, restricted, limited, conditioned, subjected to corrective action, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?
2. ☐ Yes ☐ No **Have you ever** had your **membership, participation, clinical privileges, or employment** denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?
3. ☐ Yes ☐ No **Have you ever** voluntarily/involuntarily relinquished your **membership, participation, clinical privileges or request for privileges, employment, professional license, or registration** as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?
4. ☐ Yes ☐ No **Have you ever** been reprimanded, censored, or otherwise disciplined by, or have you been subject to a corrective action agreement/plan with any **licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**
5. ☐ Yes ☐ No **Have you ever** had your certificate or participation in **any private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?
6. ☐ Yes ☐ No Are there any **charges pending or have you ever** been indicted, found guilty of a felony, misdemeanor (other than minor violations), or other offenses involving fraud, misrepresentation, dishonesty or deceit? Are you currently using illegal drugs?
7. ☐ Yes ☐ No **Have you ever** been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment?
8. ☐ Yes ☐ No **Have you ever** had any Malpractice (Professional Liability) claims or lawsuits brought against you, including pending, dismissed or dropped claims/lawsuits, settlements or final judgments? (This includes status of any pending claims previously reported.)
9. ☐ Yes ☐ No **Have you ever** had your Malpractice (Professional Liability) carrier refuse or cancel your coverage?
10. ☐ Yes ☐ No Do you have a condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing a significant health or safety risk to your patients?
11. ☐ Yes ☐ No Is your Professional Liability current with limits $1 million/$3million?

DISCLOSURE QUESTIONS & PROVIDER CONSENT

I hereby certify that to my knowledge that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary while my application is being processed. I agree to notify any changes in malpractice coverage, including changes in the insurance carrier or policy number, as they occur.

By completing this application to become a participating provider, I fully understand that any significant misstatement in, or omission from, my application to become a participating provider may constitute cause for denial of my application or the subsequent termination of my participating provider contract if my application is accepted. I understand and agree that this consent is irrevocable for any period during which I am a participating provider. Reserved is the right to base acceptance into any individual network based on criteria established.

I understand that my application may require review of information related to me on file with other entities, including but not limited to, state licensing boards, specialty boards, professional societies, malpractice carriers, and the National Practitioner Data Bank administered by the U.S. Government.

I authorize release from liability all representatives, including any agent, my state licensing board, clinics, other institutions, professional societies, professional malpractice insurance carrier(s) and any staff, for their acts performed in good faith and without malice in connection with the gathering and exchange of information as consented above or to release information as required by State or Federal laws, rules, or regulations.

I understand and agree that I have the responsibility of producing adequate information for proper evaluation of my continued professional competence, ethics and other qualifications and for resolving any doubts about such qualifications. I further understand and agree that I have a continuing affirmative duty to immediately inform of any future restrictions or revocation of my professional license, any disciplinary action, suspension or voluntary/involuntary limitation, denial of my clinical or other privileges, or any other event which may adversely reflect upon my professional competence, ethics and other qualifications as a participating provider.

I understand that subject to proper confidentiality restrictions and authorizations, my dental records will be subject to inspection for quality assurance and utilization review purposes.

Signature _____ **Date** _____

Name _____ **Dental Lic #:** _____

(Please print or type)

PROFESSIONAL LIABILITY ADDENDUM

Complete addendum if you answered "YES" to Disclosure Questions 1-10.
Attach separate sheet if necessary.

Malpractice Claim(s)

Date of Occurrence: _____ Settlement Amount: _____

Name & Address of Insurance Carrier: _____

Current Status of Claim: _____ Date Claim Resolved: _____

Details of Allegations: _____

Board Action(s): Attach copy of Board Action/Corrective Action

Date of Occurrence: _____ Date of Satisfaction/Closure: _____

Amount of Fine Paid: _____

Details of Action (conditions, limitations etc.):