

Thank you for your interest in joining Delta Dental of California's State Government Programs (DDSGP) provider network.

Delta Dental State Government Programs administers dental plans for children of low-income families whose income may be too high to qualify for coverage through the California Medi-Cal Dental Program. These programs may be subsidized with local, State and/or Federal funds and include the California Healthy Families Dental Program as well as county programs such as; Alliance Healthy Kids, Central Coast Alliance for Health, Fresno Healthy Kids, Healthy Kids Kern County, Healthy Kids Santa Barbara, Healthy Kids-Healthy Future, Kings County Healthy Kids, Merced County Healthy Kids, Partnership HealthPlan of CA, San Diego Neighborhood House Association, San Francisco Healthy Kids & Young Adults, San Joaquin Healthy Kids, San Luis Obispo Healthy Kids, San Mateo Healthy Kids, Santa Clara Healthy Kids, and Tulare Healthy Kids.

DDSGP continually seeks to strengthen our provider network and is pleased that you have considered partnering with us. Carefully review the enclosed provider enrollment packet and return the signed originals in the enclosed self-addressed envelope.

The enclosed Provider Enrollment Package includes:

- **Delta Dental of California's Participating Provider Agreement.** This document is a legal, binding agreement between you, as the billing provider, and Delta Dental of California, State Government Programs. We recommend that you carefully review the entire contract so that you are fully aware of your responsibilities as a provider with Delta Dental State Government Programs. The contract also spells out Delta Dental's responsibilities for program administration including reimbursement and quality assessment activities.
- **Delta Dental State Government Programs Fee Schedule and Benefit Summary's for DDSGP programs administered in your area.** These documents detail covered benefits, member co-payments, exclusions, limitations, and the maximum dollar amount reimbursable for each procedure.
- **Delta Dental's Provider Profile.** This document requests important information regarding you as the billing provider and also your office. This includes but is not limited to: normal business hours, staffing, mailing addresses for claim reimbursement and general correspondence, information necessary for tax reporting purposes (IRS Form 1099) and credentialing data for each treating provider.

PLEASE DO NOT FAX the enrollment documents as we are only allowed to accept documents with original signatures.

Once we receive the completed enrollment packet a DDSGP Credentialing Specialist will review the application for completeness and perform any necessary research. If information is missing

or incomplete, you may receive a written request for additional information and/or documentation. The information from your application will be entered into our State Programs provider database and the hard copy of these documents will be retained in Delta Dental's permanent provider files.

Once the enrollment process has been completed, you will receive a Welcome Packet, which will include a copy of the countersigned Provider Agreement for your files, noting your effective date; a Provider Handbook and a complete complement of forms.

Please do not treat any Delta Dental State Government Programs members until you are active in our provider network.

To avoid delays in the processing of your enrollment application, carefully follow the instruction sheet attached to the front of the Provider Profile form. As always, our Provider Toll-Free Telephone Representatives are available to answer any questions you may have. If you have any questions you may call toll-free at 800-838-4337.

By signing the participating provider agreement, you will be enrolled as a panel provider in all dental programs administered by DDSGP. You will be listed in the program directories of which you have specified on the Directory Selection List, which is included in the enrollment packet.

If DDSGP initiates the administration of a new State or County Program in your area you will receive information on this new program, including a schedule of benefits and schedule of maximum allowances. In order to participate there is no need for you to submit additional information or documentation as you will have already been credentialed and enrolled as a Provider in DDSGP. Upon acceptance, the State Government Programs Provider Handbook is available online at [HTTP://www.deltadentalins.com/group_sites/gov](http://www.deltadentalins.com/group_sites/gov). If you do not have internet access, and/or would prefer to have a paper copy of the handbook, please contact Customer Service toll-free at 800-838-4337. You may also request a copy of the handbook on CD-ROM if that would better suit your needs.

Sincerely,

DELTA DENTAL OF CALIFORNIA

State Government Programs
Provider Services Department

Enclosures

Directory Selection List

Below is the list of dental programs currently administered by Delta Dental State Government Programs (DDSGP). Once you become a network provider, you are automatically enrolled in these programs. Please review this list and select the program directories in which you would like your office name to appear. For your convenience, the first choice is “all directories”. Once you make that selection there is no need to complete the rest of the form.

Please return this completed form with your application package.

- I would like my office name to appear in all directories shown below**
- I would like my office name to appear in the directories selected from the list below**

-
- Alliance Healthy Kids
- California Healthy Families Program
- Central Coast Alliance for Health
- Fresno Healthy Kids
- Healthy Kids, Healthy Future
- Healthy Kids Kern County
- Healthy Kids Santa Barbara
- Kings County Healthy Kids
- Merced County Healthy Kids
- Partnership HealthPlan of CA
- San Diego Neighborhood House Association
- San Francisco Healthy Kids & Young Adults
- San Joaquin Healthy Kids
- San Luis Obispo Healthy Kids
- San Mateo Healthy Kids
- Santa Clara Healthy Kids
- Tulare Healthy Kids

**DELTA DENTAL OF CALIFORNIA
STATE GOVERNMENT PROGRAMS
PARTICIPATING PROVIDER AGREEMENT**

This Agreement between Delta Dental of California, a California non-profit corporation (Delta Dental) and the undersigned dentist, dental partnership, professional dental corporation, community clinic, or dental care provider (Dentist) is effective on the date stated below. The term "Dentist" also includes a public entity or political subdivision of the State of California entering into this Agreement with Delta Dental to provide Covered Dental Services to eligible Enrollees of a Program through the services of qualified, licensed dentists (Rendering Providers) engaged for that purpose. The provisions of this Participating Provider Agreement are intended to apply to the contracting party and to each Rendering Provider engaged by the party for the purpose of providing dental services pursuant to this Agreement.

RECITALS:

- A. Delta Dental is licensed as a specialized healthcare service plan by the Department of Managed Health Care of the State of California and pursuant to such license offers various State and Local Government Sponsored Dental Programs (hereinafter individually and collectively referred to as the "Program");
- B. Delta Dental desires to contract with dentists, licensed to practice dentistry in the State of California, to provide dental care to eligible Enrollees of the Program;
- C. Dentist is duly licensed to practice dentistry or is a licensed dental facility in the State of California and desires to provide services to eligible Enrollees of the Program;
- D. The general terms and conditions and definitions for terms applicable to the Program are set forth in the Delta Dental State Programs Provider Handbook ("Provider Handbook").
- E. This Agreement is limited to Covered Dental Services provided at the location set forth on the signature page of this Agreement. In the event Dentist is or becomes a Participating Provider at other locations, the rights and obligations of the parties as they relate to those locations are or shall be set forth in separate agreements. This Agreement does not amend or otherwise effect those agreements in any manner.

I. SELECTION AND PARTICIPATION

- 1.0 Eligibility:** To be eligible to participate in the Program, Dentist must have submitted all required credentialing documents and been approved by Delta Dental as meeting its credentialing criteria.
- 1.1 Selection:** In its sole discretion, Delta Dental may select Dentist for participation in the Program for which Dentist agrees to participate and Delta Dental determines Dentist to be eligible, and for which Delta Dental has a need for Dentist's services.
- 1.2 Notification of Selection:** Delta Dental shall notify Dentist in writing of selection as a Participating Provider in the Program.
- 1.3 Acceptance:** Dentist shall automatically be deemed to have accepted participation in the Program for which he/she is selected unless Dentist declines participation in writing within thirty (30) days of receipt of notification.

II. DENTIST'S OBLIGATIONS

- 2.0 Covered Dental Services:** The basic scope of benefits and exclusions for the Program are set forth in the Provider Handbook. Dentist shall provide necessary Covered Dental Services to eligible Enrollees who select Dentist or who may be assigned to Dentist.
- 2.1 Availability:** Dentist shall ensure Covered Dental Services are available during regular business hours. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week, including vacations and holidays. Dentist may not impose any limitations on the acceptance or treatment of Enrollees not imposed on other patients.
- 2.2 Eligibility Verification:** Dentist shall verify an Enrollee's eligibility to receive Covered Dental Services before each visit in accordance with the procedures set forth in the Provider Handbook. Failure to follow the eligibility verification procedures set forth in the Provider Handbook may result in forfeiture of payment, including Co-payments, for Covered Dental Services.

- 2.3 Complaint and Grievance Procedures:** Dentist shall cooperate with Delta Dental in identifying, processing and resolving Enrollee complaints and grievances pursuant to applicable Complaint and Grievance Procedures described in the Provider Handbook. Dentist shall comply with all final complaint and grievance determinations made by Delta Dental.
- 2.4 Claims and Other Data:** Dentist shall provide Delta Dental with data in the manner and in accordance with the procedures set forth in the Provider Handbook. Upon request, Dentist shall also provide such other information, as will enable Delta Dental to meet federal, state and local reporting requirements. The use of electronic data/claims submissions and billing agents shall be subject to the rules and regulations stated in the Provider Handbook.
- 2.5 Standard of Care:** Dentist and Rendering Providers shall maintain the dentist/patient relationship with Enrollees and shall be solely responsible to Enrollees for dental advice and treatment. All Covered Dental Services shall be provided in accordance with generally accepted dental practice and standards prevailing in the professional community at the time of treatment.
- 2.6 Licensure:** Dentist warrants and represents as a material term of this Agreement that Dentist and each Rendering Provider are and shall continue to be, as long as this Agreement remains in effect, the holders of currently valid, unrestricted licenses, certificates and/or approvals required by State and Federal law to provide Covered Dental Services to Enrollees. Dentist further warrants and represents that neither Dentist's nor any Rendering Provider's license has been suspended, revoked or limited within the past five (5) years.
- 2.7 Facilities and Equipment:** Dentist shall provide and maintain facilities that are of adequate capacity and are clean, safe and readily accessible to Enrollees. All equipment used by Dentist and Rendering Providers shall be licensed and regularly checked as required by State and Federal law to ensure that it meets health and safety standards, is environmentally safe and technically accurate. Any hazard identified by inspection shall be promptly corrected. Dentist shall maintain and, upon request, shall provide Delta Dental with all equipment maintenance and calibration records and inspection certificates or reports.
- 2.8 Approval of Rendering Providers:** Dentist shall provide Delta Dental with a complete list of Rendering Providers, together with individual credentialing information required by Delta Dental for each Rendering Provider. Dentist warrants that only Rendering Providers credentialed and approved by Delta Dental shall provide Covered Dental Services to Enrollees. Dentist shall provide at least thirty (30) days written notice to Delta Dental of the addition or termination of any Rendering Provider(s) and shall obtain the written approval of Delta Dental prior to allowing a new Rendering Provider(s) to deliver Covered Services to Enrollees.
- 2.9 Rendering Provider Compliance with Provider Agreement:** Dentist shall require that all Rendering Providers acknowledge this Agreement and comply with its applicable terms.
- 2.10 Required Disclosures:** Dentist shall notify Delta Dental immediately in writing upon the occurrence or discovery of any of the following:
- a) Dentist's license to practice in California or the license of a Rendering Provider is suspended, revoked, terminated or subject to terms of probation or to other restriction;
 - b) Dentist or a Rendering Provider becomes the subject of any disciplinary proceeding or action before the California Board of Dental Examiners;
 - c) Dentist or a Rendering Provider ceases to participate, is suspended or loses eligibility to participate in the Medi-Cal Dental Program;
 - d) Dentist or a Rendering Provider is convicted of fraud or a felony;
 - e) Dentist or a Rendering Provider fails to maintain the insurance coverage required under Paragraph 2.13 of this Agreement, or to replace coverage which is canceled or terminated, as specified therein;
 - f) Dentist or a Rendering Provider learns of any malpractice action against Dentist or the Rendering Provider, or becomes aware of a malpractice judgment or settlement against Dentist or the Rendering Provider;
 - g) Dentist or a Rendering Provider files a voluntary petition or an involuntary petition is filed against Dentist or a Rendering Provider seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other laws governing insolvency or debtor relief;

- h) An act of nature or any event beyond Dentist's reasonable control occurs which substantially interrupts or interferes with all or a portion of Dentist's business or which has a material adverse effect on Dentist's ability to perform hereunder;
- i) There is a change in Dentist's or a Rendering Provider's business address;
- j) There is a change in the bylaws, membership, ownership, and/or officers of Dentist's dental practice/corporation; or
- k) Any other situation arises which could reasonably be expected to affect Dentist's or a Rendering Provider's ability to carry out the obligations of this Agreement.

To the extent reasonably appropriate and subject to any applicable State or Federal fair hearing requirements, Dentist shall immediately restrict, suspend or terminate a Rendering Provider from providing Covered Dental Services to Enrollees upon the occurrence of any of the events set forth in subparagraphs a) through e) above. If Dentist fails to act as required by this Paragraph with respect to a Rendering Provider, Delta shall have the right to immediately prohibit the Rendering Provider from continuing to provide Covered Dental Services to Enrollees.

2.11 Legal Compliance: Dentist and Rendering Providers shall:

- a) not unlawfully differentiate or discriminate against an Enrollee, employee or applicant for employment on the basis of source of payment, access to or need for Covered Dental Services, race, religion, color, national origin, ancestry, place of residence, physical handicap, medical condition, marital status, sexual orientation, age or sex; and
- b) comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Public Law 103-227, US. Pro-Children Act of 1994 [20 USC 6081 et. seq.] and Section 1352 of Title 31, United States Code regarding prohibitions against using federal funds for lobbying; and
- c) not employ or contract with, directly or indirectly, entities or individuals excluded from participation in Medicare or Medi-Cal under sections 1128 or 1128A of the Social Security Act, for the provision of dental services, utilization review, medical social work or administrative services; and
- d) not condition treatment or otherwise discriminate on the basis of whether an Enrollee has executed an advance directive (as advance directive is defined under federal law).

2.12 Confidentiality of Delta Information: Dentist and Rendering Providers shall keep confidential and take necessary precautions to prevent the unauthorized disclosure of Delta Dental confidential and proprietary information, including without limitation its financial arrangements with Participating Providers and any other information compiled or created by Delta Dental and identified in writing as confidential and proprietary. Upon the termination or expiration of this Agreement, Dentist shall return to Delta Dental all confidential and proprietary information in the possession of Dentist or a Rendering Provider.

2.13 Insurance: Dentist and Rendering Providers performing services under this Agreement shall secure and maintain from insurance companies acceptable to Delta Dental and approved to conduct business in the State of California, professional and general liability insurance and such other insurance as required by reasonably sound business judgment to protect the insured and the insured's partners, shareholders, directors, officers, members, employees and agents against losses and liabilities attributable to their acts or omissions in the performance of this Agreement. Such insurance shall have limits of coverage considered reasonably adequate for the risk insured against and consistent with local custom and practice. Dentist and Rendering Providers shall deliver certificates of insurance to Delta Dental upon request and shall obligate the carrier of each such insurance policy to give Delta Dental written notice by registered mail at least thirty (30) days prior to cancellation or other termination of such policy.

III. DELTA'S OBLIGATIONS

3.0 Administration: Delta Dental shall perform or contract for those services necessary to the administration of the Program.

3.1 Payment: Delta Dental shall pay Dentist directly for Covered Dental Services in accordance with Article IV (Compensation) of this Agreement.

3.2 Eligibility/Authorizations: Delta Dental shall issue Program identification cards to Enrollees, confirm eligibility and authorize Covered Dental Services in the manner set forth in the Provider Handbook.

- 3.3 Coverage Determinations:** Delta Dental shall be solely responsible for disseminating information regarding coverage and for interpreting and making final coverage determinations for the Program.
- 3.4 Provider Handbook:** Delta Dental shall make available to Dentist the Provider Handbook describing Delta Dental's general policies and procedures and the policies and procedures of the Programs. The Provider Handbook shall be updated by Delta Dental on a periodic basis in accordance with this Agreement.
- 3.5 Rationale For Rejection of Claim:** Delta Dental shall, upon demand, disclose the specific rationale used in rejecting a provider or patient coverage claim.
- 3.6 Modification of Authorization:** Delta Dental shall not retroactively deny, rescind, or modify authorization for specific treatment by a provider after the provider has rendered services in good faith pursuant to the authorization. This section shall not be construed to expand or alter the benefits available to an Enrollee.

IV. COMPENSATION

- 4.0 Claim Submission Requirements:** Dentist agrees to follow the claim processing policies described in the Provider Handbook. Dentist agrees to file claims for services on forms acceptable to Delta Dental within six (6) months after the date services were performed.
- 4.1 Certification of Services:** Dentist must certify that services listed on the claim form have been personally provided to the patient by Dentist, or under his/her direction, by another person(s) eligible under the Program to provide such services and such person(s) must be designated on the claim form. Dentist shall also certify that the services were, to the best of Dentist's knowledge, necessary to the health of the patient.
- 4.2 Fees:** Delta Dental shall pay Dentist for Covered Dental Services provided to Enrollees, fees in accordance with the attached Confidential Fee Schedule.
- 4.3 Copayments:** Dentist is authorized to bill and collect Co-payments from the Enrollee not to exceed the amounts specified in the Provider Handbook.
- 4.4 Prohibition Against Certain Billings and Collections:** Dentist agrees to accept fees described in Paragraph 4.2 and Co-payments pursuant to Paragraph 4.3, as payment in full for Covered Dental Services and not to seek any surcharge or other additional payment not provided for in the Program, regardless of whether or not payment is received from Delta Dental. Whenever Delta Dental receives notice of a surcharge, it shall take appropriate action. Neither Enrollees nor the State of California shall be liable to Dentist for any sums owed to Dentist by Delta Dental. The foregoing shall not preclude Dentist from billing and collecting Co-payments pursuant to Paragraph 4.3, third party collections in accordance with Paragraph 4.5, or non-covered dental services provided in accordance with Paragraph 4.6.
- 4.5 Third Party Collections:** Dentist shall cooperate with Delta Dental in the proper collection of third party payments including the coordination of benefits, workers' compensation, third party liens and other third party liability according to the procedures set forth in the Provider Handbook.
- 4.6 Non-covered Dental Services:** Dentist shall not bill or collect from an Enrollee any charges in connection with a dental service even though that service is not a Covered Dental Service or is an Optional Treatment plan that is more expensive treatment than is customarily provided unless an executed Financial Responsibility or Optional Treatment Form has been obtained from the Enrollee or the Enrollee's legal representative in accordance with the procedure set forth in the Provider Handbook. In the event Dentist has obtained the appropriately executed form, Dentist agrees to charge no more than:
- a) for non-covered dental services, Dentist's filed and approved Delta Dental fee for the service, or
 - b) for Optional Treatment, the difference between Dentist's filed and approved Delta Dental fee for the Optional Treatment and the covered procedure, plus any applicable Co-payment for the covered procedure.
- 4.7 Care to Canceled or Ineligible Persons:** Pursuit of repayment for services provided to ineligible or retroactively canceled Enrollees shall be in accordance with the terms set forth in the Provider Handbook.
- 4.8 Deductions and Withholds:** Delta Dental shall have the right to deduct and setoff from amounts due to Dentist, any amounts owed by Dentist to Delta Dental or to other persons or entities as a result of Dentist's failure to fulfill any business or patient obligation under this Agreement, including without limitation, Dentist's failure to comply with Delta Dental's quality and utilization review program or complaint and grievance procedure. Enrollees shall not be liable to Dentist for any amount deducted or setoff by Delta Dental or by

the Program, if self-funded, and Dentist agrees not to attempt to collect any setoff amount from Enrollees or maintain any action at law against Enrollees to collect such amounts.

- 4.9 Non-Reimbursable Service Claims Submission:** The submission of a claim for items or services which has not been provided as claimed, is not reimbursable under the Program and is subject to Section 550 of the California Penal Code.

V. QUALITY AND UTILIZATION REVIEW

- 5.0 Delta's Responsibilities:** Delta Dental is required by law to conduct quality and utilization review activities that identify, evaluate and remedy problems relating to access, continuity and quality of care, utilization and the cost of services. Accordingly, Delta Dental shall conduct a quality and utilization review program as described in the Provider Handbook and shall maintain standards, policies and procedures for credentialing and recredentialing dentists and other health care professionals and facilities providing Covered Dental Services to Enrollees. Delta Dental's program shall include the establishment of peer review panels and committees to conduct quality of care and utilization review activities in accordance with applicable State and Federal laws and regulations, including, but not limited to California Health and Safety Code Sections 1370 and 1370.1. Delta Dental may engage accreditation or review organizations in connection with its quality and utilization review activities. All quality and utilization review forms, records and other information in Delta Dental's possession shall remain the property of Delta Dental and shall remain confidential.
- 5.1 Dentist's Responsibilities:** Dentist shall have a written quality and utilization plan to identify, evaluate and remedy problems relating to access, continuity, quality, utilization and cost of services provided or authorized by Dentist or a Rendering Provider. Dentist and Rendering Providers shall cooperate and comply with Delta Dental and the designated representatives of organizations engaged by Delta Dental in connection with its quality and utilization review activities.
- 5.2 Shared Records:** Upon Delta Dental's request, Dentist shall make any records of its quality and utilization review activities pertaining to Enrollees available to Delta Dental's quality and utilization review committee. Such sharing of records between Delta Dental and Dentist shall be in accordance with and limited by Sections 1157 of the California Evidence Code and 1370 of the California Health and Safety Code and shall not be construed as a waiver of any rights or privileges conferred on either party by those statutes.

VI. RECORDS

- 6.0 Dental Records:** Dentist shall ensure that an accurate and complete patient dental record is established and maintained for each Enrollee. At a minimum, the record shall include all information about the Enrollee and a description of all services rendered to the Enrollee as dictated by generally accepted dental practice and standards and as required by the Provider Handbook.
- 6.1 Access to Dental Records:** Subject to compliance with applicable Federal and State laws and professional standards regarding the confidentiality of dental records, Dentist shall assist Delta Dental in achieving continuity of care for Enrollees through the maximum sharing of dental records for services rendered to Enrollees. Dentist's obligations under this Paragraph 6.1 shall include, without limitation:
- a) Providing Delta Dental with copies of Enrollee dental records that are in the custody of Dentist or a Rendering Provider;
 - b) Allowing Delta Dental authorized personnel, its designated representatives, accreditation and review organizations and government agencies access to such records on Dentist's or a Rendering Provider's premises during regular business hours;
 - c) Transmitting information from an Enrollee's dental records by telephone to Delta Dental for purposes of authorization or other quality and utilization review activities; and
 - d) Upon reasonable request, providing copies of an Enrollee's dental records to any other Participating Dentist treating such Enrollee.
- 6.2 Inspection, Audit and Maintenance:** Dentist shall maintain the confidentiality of all Enrollee identifiable information, dental records and treatment in accordance with State and Federal law. Dentist shall maintain such records and provide such information to Delta Dental, the United States Department of Health and Human Services, the State of California Department of Health Services and the California Department of Corporations as may be necessary for compliance by Delta Dental with State and Federal law including, but not limited to the California Knox-Keene Health Care Service Plan Act of 1975, as amended, and the rules and regulations duly promulgated thereunder, for a period of at least five (5) years. All facilities, offices,

records, books and papers of Dentist and Rendering Providers pertaining to Enrollees shall be open to inspection by Delta Dental, its designated representatives, accreditation and review organizations, and State and Federal authorities during normal business hours. Dentist shall comply with any requirements or directives issued by Delta Dental, accreditation and review organizations and government agencies as a result of such evaluation, inspection or audit of Dentist and Rendering Providers. The provisions of this Paragraph shall survive termination of this Agreement for the period of time required by State and Federal Law.

VII. TERM AND TERMINATION

- 7.1 Term:** When executed by both parties, this Agreement shall commence on the Participation Effective Date stated below, and shall continue in effect until terminated in accordance with Paragraph 7.2.
- 7.2 Termination:** Either party may terminate this Agreement either in its entirety or as to an individual Program on ninety (90) days written notice. Delta Dental may immediately terminate this Agreement upon the occurrence of any of the events set forth in Paragraph 2.10 a) through e), (Required Disclosures).
- 7.3 Availability of Funding:** It is mutually understood between the parties that the Program covered under this Agreement depends upon the availability of government funding. In the event funding for the Program is terminated or significantly reduced, the terms and conditions for the Program may be amended to reflect the reduction in funds or the Program may be terminated in its entirety.
- 7.4 Continuing Obligations Upon Termination:** In the event of notice of termination of this Agreement or a Program, Dentist shall continue to schedule and honor existing appointments of Enrollees until the effective date of termination. As of the effective date of termination of this Agreement or the Program, the provisions of this Agreement shall be considered of no further force or effect whatsoever and each of the parties shall be relieved and discharged here from, except that:
- a) Termination shall not affect any rights or obligations that have previously accrued or shall thereafter arise with respect to any occurrence prior to the effective date of termination and any such rights and obligations shall continue to be governed by the terms of this Agreement;
 - b) Unless Delta Dental makes other reasonable and medically appropriate provision for the performance of services, Dentist shall complete all Covered Dental Services begun (but not completed) prior to termination.

VIII. MISCELLANEOUS PROVISIONS

- 8.0 Amendments:** Unless otherwise specifically stated in this Agreement to the contrary, this Agreement may be amended or changed only by mutual written consent of the parties. Notwithstanding the foregoing, Delta Dental may, upon thirty (30) calendar days written notice to Dentist, amend this Agreement, or Provider Handbook to implement the provisions of and comply with its obligations under State and Federal law or to meet its administrative needs. Such amendments shall be effective at the end of the thirty (30) calendar day notice period and Dentist shall be bound by such amendment unless Dentist provides Delta Dental with notice of objection within the thirty (30) calendar day notice period and reasonably demonstrates to Delta Dental that the amendment has a material adverse economic effect upon Dentist. If a material adverse effect upon Dentist is reasonably demonstrated by Dentist, the parties shall agree in good faith to an additional amendment to equitably address such adverse economic impact. If the parties are unable to agree, this Agreement shall terminate ninety (90) days after the original notice of amendment. Dentist shall comply with any amendment required by law until the effective date of termination
- 8.1 Governing Law.** This Agreement shall be governed, construed and enforced in accordance with the laws of the State of California and the United States of America, including, without limitation, the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations adopted thereunder. Any provisions required to be in this Agreement by State or Federal law or by Government Agencies with jurisdiction over Delta Dental shall bind Delta Dental and Dentist whether or not expressly provided in this Agreement.
- 8.2 Incorporation by Reference:** All exhibits, addenda and attachments to this Agreement, including the Provider Handbook, are an integral part of this Agreement and are incorporated in full herein by this reference.
- 8.3 Entire Agreement:** This Agreement, fee schedules, appendices, and amendments hereto, contains all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement and supersedes all prior agreements, either oral or in writing, with respect to the subject matter hereof.

- 8.4 Independent Contractor Relationship:** The relationship between Delta Dental and Dentist is that of independent contractors. Neither Dentist nor Rendering Providers or their respective employees or agents are or shall be construed to be employees or agents of Delta Dental and neither Delta Dental nor its employees or agents are or shall be construed to be members, partners, employees or agents of Dentist.
- 8.5 Indemnification:** Delta Dental and Dentist shall each defend, indemnify and hold harmless the other party and, its directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability arising out of or related to the performance or nonperformance by the indemnifying party or their respective employees or agents under this Agreement
- 8.6 Assignment:** This Agreement, being intended to secure the personal services of Dentist and Rendering Providers, shall not be subcontracted, assigned, transferred or pledged in any way by Dentist and shall not be subject to execution, attachment or similar process, except that Delta Dental may assign this Agreement and its rights, interests and benefits here under to any Delta Dental parent company, affiliate or related entity.
- 8.7 Disputes:** Disputes between Delta Dental and Dentist arising out of this Agreement shall be resolved through the Provider Complaint and Grievance Procedure described in the Provider Handbook.
- 8.8 Notice:** Notice to either party shall be sent to that party’s address of record by United States mail, postage prepaid, return receipt requested. Any such notice so mailed shall be deemed to have been served upon and received by the addressee 72 hours after the notice has been deposited in the U.S. mail. Either party shall have the right to change the place to which notice is being sent by giving written notice to the other of any change of address.
- 8.9 Stockholder Information:** The names of the officers and owners of Dentist’s corporation owning more than ten percent (10%) of the stock issued by Dentist and major creditors holding more than five percent (5%) of the debt of Dentist’s corporation shall be attached to this Agreement on the form identified as Appendix B.
- 8.10 Signatures:** The signatories hereto represent and warrant that they have read the Agreement, understand it and are authorized to execute it on behalf of their respective principals or co-owners.

IN WITNESS WHEREOF, each of the undersigned has individually executed (in the case of a single dentist) or has caused this Agreement to be executed by its duly authorized representative (in the case of a dental partnership, professional dental corporation, dental clinic, or public entity, as of the date(s) written below.

(Print Legal Name of Contracting Dentist, Dental Group, Dental Clinic or Public Entity)

DELTA DENTAL OF CALIFORNIA:

Authorized Signature

Signature

Print Name and Title (if applicable) of person signing

Title

Date: _____

Date: _____

Tax Identification Number: _____

Participation Effective Date: _____

Billing Provider ID: _____
(If not known, leave this space blank)

National Provider Identifier: _____

This Agreement is limited to the Contracting Office Location(s) set forth below:

Contracting Office Location:

Street

City/State/Zip

APPENDIX B
SHAREHOLDERS' REPORTING

Stock issuances to individuals owning more than 10% of said Corporation are:

(Please print name and address or provide list as attachment)

NAME	ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Major creditors holding more than 5% of the debt of said Corporation are:

DELTA DENTAL OF CALIFORNIA STATE GOVERNMENT PROGRAMS PROVIDER PROFILE COMPLETION GUIDE

Please remember: Information supplied is **ONLY** for the office address which appears on the PROVIDER PROFILE form, Page 1—Section I. BILLING PROVIDER INFORMATION. A separate agreement needs to be completed for **each service office**.

I. Billing Provider Information

Complete your billing provider name, license number, tax ID or Social Security Number, DBA or group/clinic name, street address, including city, county, state and zip code, your telephone and FAX number including area code. Indicate the business type and practice type. **Please check all of this information carefully.**

II. “Pay to” Office Information

If you select to receive mail at a different address, please indicate in the “Pay to” address section.

III. Accessibility

Please indicate your hours for each day. For example: 8:00 a.m. - 5:00 p.m., or 7:00 a.m. – 7:00 p.m. If your office is closed on any day, please indicate this with a zero (0).

Be sure to indicate **all** languages that are *fluently* spoken in your office.

If you are currently enrolled in the Denti-Cal Program please indicate your Biller ID number.

IV. Treating Provider Information

Please complete a separate form for **all** dentists who will treat patients in this office. This will include you, if you treat patients at this office.

Also, please indicate if each dentist is a CHDP provider, CCS provider, Safety-Net, or Traditional provider (see definitions below.)

CHDP Provider: As an expansion of the Federal Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, the State has developed the Child Health and Disability Prevention (CHDP) treatment mandate, which is a program that provides health assessment screenings to Medi-Cal eligible children from birth to age 19.

CCS Provider: A special program available to patients from birth to age 20. California Children’s Services (CCS) authorizes services to correct birth defects or other serious physical conditions resulting from disease, accident or other causes. Patients must apply to CCS to be eligible for services under this program.

Safety-Net Provider: These include dental education institutions, hospital-based dental programs, dental clinics sponsored by government agencies, as well as private organizations, and providers of a limited range of dental services, including, but not limited to, school-based and school-linked clinics.

Traditional Provider: Those providers who have submitted a minimum of 25 unduplicated (individual) claims/encounters for treatment of Denti-Cal beneficiaries during the last calendar year.

DELTA DENTAL OF CALIFORNIA STATE GOVERNMENT PROGRAMS PROVIDER PACKAGE CHECKLIST

This **CHECKLIST** is provided to help you complete your Provider Enrollment Packet. Please remember that **ALL** documents must be legible and complete. Your documents will be screened for acceptability. Once credentialing has been completed, a copy of the counter-signed Provider Agreement will be returned to you for your files, noting the effective date of the Agreement. **You should not treat any members prior to the effective date.**

Please be sure to enclose the following documents in the self-addressed envelope enclosed. **DO NOT FAX** this information. We can *only* accept completed documents with **original, inked signatures**.

IMPORTANT ITEMS TO BE RETURNED TO DELTA:

- Completed Provider Profile (Page 1) BILLING PROVIDER INFORMATION.
- Complete the Treating PROVIDER CREDENTIALING INFORMATION. (EACH PROVIDER MUST COMPLETE AND SIGN A SEPARATE PAGE). Please photocopy if your office has more than one treating provider. (Original inked signatures).
- Original, inked signature (no copies) of the billing provider, CEO or director on the *Provider Agreement* (page 7 of the contract).
- Completed Appendix B (if applicable).
- Current copy of valid license issued by the State of California Board of Dental Examiners (wallet size), for **each** Treating Provider.
- Copy of current DEA permit, for **each** Treating Provider.
- Current copy of the Professional Liability Insurance. Please include a copy for **each Treating Provider**. It must include:
 - Name of Policy Holder
 - Name of Policy Carrier

Please choose the category that closely matches the amount of professional liability (errors and omissions) insurance you currently have (per individual/per incident); (Please note that Delta's minimum coverage is \$500,000/\$1,000,000.)

- | | | |
|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> \$1,000,000/\$3,000,000 | <input type="checkbox"/> \$3,000,000/\$3,000,000 |
| <input type="checkbox"/> Less than 500,000/\$1,000,000 | <input type="checkbox"/> \$1,500,000/\$4,500,000 | <input type="checkbox"/> \$5,000,000/\$5,000,000 |
| <input type="checkbox"/> \$500,000/\$1,500,000 | <input type="checkbox"/> \$2,000,000/\$6,000,000 | <input type="checkbox"/> Over \$5,000,000 |

- Current coverage dates
- General Liability for office premises (**Primary Care Dentist (PCD)**).

- Curriculum Vital (academic history) for **each** treating provider (**PCD Providers Only**).
- Current CPR (cardiopulmonary resuscitation certificate) for **each** treating provider (**PCD Providers Only**).

- Copy of **each** treating provider's work history (**PCD Providers Only**).
- Copy of Advanced Specialty Education Certificate for **each** Treating Provider, (if applicable).
- Copy of the current permit if General Anesthesia OR Conscious Sedation is administered in the practice (if applicable).
- Current, valid, legible copy of the official Internal Revenue Service (IRS) document (**issued by the IRS**) indicating the IRS Identification Number assigned to the provider. If using a Taxpayer Identification Number (TIN), submit **one** of the following: form 941, IRS letters 147c or SS-4 or deposit form 8109.

Or,

If Sole Proprietor using a Social Security Number, complete an IRS W-9 form.

- Taxpayer Identification Number (TIN) Enrollment form.
- Would you like to sign up for Direct Deposit? Yes No (If yes, please complete the appropriate form included with the contract application.)

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL US AT:
800-838-4337**

PROVIDER PROFILE

Important: Please type or print **clearly** in ink.
All items must be completed or marked "N/A".
Incomplete applications will be returned.

Program Name

I. Billing Provider Information

Billing Provider Name _____ DDS DMD (circle one)
 DBA or Group/Clinic Name _____
 License Number _____ Tax ID _____ (I.R.S. Document Required)
 National Provider Identifier (NPI) _____
 Street Address _____
 City _____ County _____ State _____ Zip Code _____
 Telephone (____) _____ - _____ FAX (____) _____ - _____
 Email address _____

Business Type: Individual Partnership Corporation **Practice Type:** Individual Group Clinic/ School

Is your practice currently open and receiving patients? Yes No
 If no, please provide us with an estimated date of when you will be open for business ____/____/____
 Are you a General Practitioner (GP) **OR** a Specialist (SP) (copy of certificate required)
 If Specialist, indicate: Endo OS Perio Pedo Ortho Other _____
 If Specialist, do you have patient age limitations? Yes No If yes, please list age limitations _____
 Do you wish to be listed in the directory? Yes No

II. "Pay to" Office Information

If you require your "Pay to" address to be different than above (i.e., post office box), please complete the following information.

Address _____ City _____
 State _____ Zip Code _____ Telephone (____) _____ - _____ FAX (____) _____ - _____

III. Accessibility

Hours of Operation: (example: 9-6 or 8:30-5) Mon _____ - _____ Tues _____ - _____ Wed _____ - _____
 Thurs _____ - _____ Fri _____ - _____ Sat _____ - _____ Sun _____ - _____
 Do you have a 24-hour answering service or machine available? Yes No
 Is there a dentist on call for emergency treatment 24-hours a day? Yes No
 Is this office wheelchair accessible? Yes No
 What languages, other than English, do you and/or your staff speak fluently? _____

Are bilingual Patient History and Informed Consent forms used? Yes No
 List any special features of your office (e.g. transportation assistance, American Sign Language, etc.) _____

Are you currently enrolled in the Denti-Cal program? Yes No If yes, Denti-Cal ID # _____
 How many **total** active patients do you currently see? _____
 How many **new patients** can you practically absorb into your practice over the next year? _____
 What is the current appointment availability? Initial _____ wk Routine _____ wk Hygiene _____ wk
 Number of RDH's: Full Time _____ Part Time _____ / _____ (#/hrs per week available)
 Number of RDA's: Full Time _____ Part Time _____ / _____ (#/hrs per week available)
 Number of other Auxiliary staff Full Time _____ Part Time _____ (#/hrs per week available)

IV. Treating Provider Credentialing Information: Complete a separate form for each licensed dentist that will be providing treatment in this service office. If additional pages are required please photocopy this page. Please attach a **complete work history or resume**, including to/from dates and locations.

* Denotes required fields.

A. *Treating Provider Name _____ DDS DMD (circle one)
 (First) (MI) (Last)

*Date of Birth: ____/____/____ *SSN: ____-____-____

Gender: Male Female Ethnicity _____
 Languages Spoken _____

*Dental License Number _____ *Exp. Date ____/____/____ (current copy required-wallet-size)

National Provider Identifier (NPI) _____

General or Specialty OS Perio Pedo Endo Ortho Other _____
 (copy of specialty certificate required)

*Dental School _____ State or Country _____ Date Graduated ____/____/____
 If a foreign dental school graduate, are you certified by the Education Council for Foreign Graduates? Yes No
 If you have completed a residency, Where? _____ Date ____/____/____

*Malpractice Carrier: _____ Policy Number: _____
 Expiration Date: ____/____/____ Coverage Limits: _____ (current copy required)

*DEA License #: _____ Exp. Date: ____/____/____ (current copy required)
 Oral Conscious/ Conscious Sedation Permit #: _____ or GA Permit # _____ Exp. Date: ____/____/____

Are you a CHDP Provider? Yes No CCS Provider? Yes No
 Are you a Safety-Net Provider? Yes No Traditional Provider? Yes No

*Hours Available: Full-Time _____ # of hrs per week Part-Time _____ # of hrs per week

List of Hospital(s) where you have staff privileges _____
 Indicate type of privilege: Active Courtesy Associate Restricted Other
If privileges are Restricted or Other, attach explanation.

A. *Each treating provider must complete the following section. If you answer yes to any of the following questions, please provide a detailed description below or on an attached sheet.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever had your dental license revoked, suspended or canceled? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been denied a dental license or certification by a specialty board? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have there been any adverse peer review actions, Board of Dental Examiner actions, or 805 Reports filed against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has your professional liability insurance ever been denied, canceled or non-renewed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the past 5 years have any claims or suits of alleged malpractice ever been brought against you or are you aware of any circumstances that might lead to such a claim or suit? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you now or ever had any chronic physical or emotional impairment that may affect your ability to practice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had your permit to prescribe drugs revoked or suspended? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has any hospital ever censured, restricted, suspended or revoked your privileges? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been convicted of a crime other than a minor traffic violation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has your membership in any professional society or association ever been canceled, revoked, or censured? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. To your knowledge, have any fee complaints been registered against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have any regulatory authorities brought documented charges against you for alleged inappropriate fees or quality of care issues? | <input type="checkbox"/> | <input type="checkbox"/> |

If you have answered **yes** to any of the above, *please attach an explanation.*

I certify under penalty of perjury that the above information is true, accurate and complete to the best of my knowledge.

Signature of Treating Provider _____

Date _____

Information on TIN Enrollment Form (Excerpted from IRS Form W-9)

Purpose of Form

A business that is required to file an information return with the IRS must obtain your correct TIN to report income paid to you. Furnish your correct TIN to the requester (the business asking you to furnish your TIN) and, when applicable, (1) to certify that the TIN you are furnishing is correct, (2) to certify that you are not subject to backup withholding, and (3) to claim exemption from backup withholding* if you are an exempt payee. Furnishing your correct TIN and making the appropriate certifications will prevent certain payments from being subject to backup withholding.*

***What is Backup Withholding?**

Businesses making certain payments to you after 1992 are required to withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." If you give the requester your correct TIN and make the appropriate certifications, your payments will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. The IRS notifies the requester that you furnished an incorrect TIN, or
3. You do not certify your TIN.

Specific Instructions

Name

If you are an individual, you must generally provide the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, please enter your first name, the last name shown on your social security card and your new last name.

If you are a sole proprietor, you must furnish your individual name and employer identification number (EIN). You may also enter your business name or "doing business as" name on the business entity line. Enter your name(s) as shown on your social security card and/or as it was used to apply for your EIN on Form SS-4.

What Name and Number to Give the Requester

Please refer to *Guidelines for the Delta Taxpayer Identification Number (TIN) Enrollment Form*.

Penalties

Failure to Furnish TIN

If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil Penalty for False Information with Respect to Withholding

If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 criminal penalty.

Criminal Penalty for Falsifying Information

Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs

If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Privacy Act Notice

Section 6109 requires you to furnish your correct TIN to businesses that must file information returns with the IRS to report income paid to you. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable payments to a payee who does not furnish a TIN to a payer. Certain penalties may also apply.



Delta Dental of California
 State Government Programs
 P.O. Box 537010
 Sacramento, California 95853-7010

DIRECT DEPOSIT ENROLLMENT FORM

1. New Enrollment Change Enrollment Information Discontinue Enrollment

2. Provider Information:

Billing Provider ID #: _____

NPI #: _____ Provider Service Office #: _____

Provider DBA Name: _____

Provider's name as shown on bank account: _____

3. Banking Information:

Please attach a VOIDED check from your bank account to this form in the space below:

TAPE YOUR VOIDED CHECK HERE

4. Type of Account:

Checking

Savings

5. Discontinued Enrollment:

Reason for Discontinued Enrollment: _____

6. Provider's Signature:

 Provider's Signature (Requires Provider's Original Signature)

 Date

DO NOT WRITE BELOW THIS LINE

For Office Use Only

Date Entered: _____ Initials: _____

Instructions for Completing the Direct Deposit Enrollment Form

1. Check "New Enrollment," "Change Enrollment Information" or "Discontinue Enrollment".
2. Fill in your Billing Provider ID number, NPI number, Provider Service Office number, "Doing Business As" Name and the name shown on the bank account records.
3. Attach a VOIDED check to the form. Tape it to the blank space provided. Check the appropriate box for "Checking" or "Savings" to indicate the type of bank account.
4. For discontinued enrollment only: Fill in your reason(s) for discontinued enrollment.
5. Sign your name and fill in date. The **provider's original signature** is required. Rubber stamp signatures or initials cannot be accepted.
6. Send completed form to: **Delta Dental of California**
P.O. Box 537010
Sacramento, CA 95853-7010