DELTA DENTAL

Thank you for your interest in joining Delta Dental of California's State Government Programs (DDSGP) provider network. DDSGP continually seeks to strengthen our provider network and we are pleased that you are considering partnering with us.

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 Healthy Families Program as well as county programs such as Central California Alliance for Health, HPSM Care*Advantage* (HMO), Partnership HealthPlan of CA, PHC Partnership*Advantage* (HMO SNP), San Diego Neighborhood House Association, San Francisco Healthy Kids, and San Mateo Healthy Kids.

Carefully review the enclosed Provider Enrollment Packet and Schedule of Maximum Allowances (SMA), and return the completed packet to:

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

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. To avoid delays in the processing of your enrollment application, carefully follow the list of required documents listed on the Provider Completion Guide page and on section 3 of the Credentialing Information Form included in this packet.

Once the enrollment process has been completed, the information from your application is entered into our State Government Programs Provider database and the hard copy of these documents will be retained in Delta Dental's permanent provider files. You will then receive a Welcome Packet, which includes a copy of the countersigned Provider Agreement, noting your effective date, for your files, a Provider Handbook on CD Rom and a complement of forms. If you would prefer to have a paper copy of the handbook, please contact Customer Service toll-free at 800-838-4337 or you can print one from our website at deltadentalins.com/gov.

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

If DDSGP initiates the administration of a new State or County Program in your area, you will receive information on this new program and an SMA. 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. Should you have any questions or concerns, please call us toll-free at 800-838-4337.

Sincerely,

DELTA DENTAL OF CALIFORNIA

Valerie Georges, Manager
Dentist Network Administration and Contracting
State Government Programs

DELTA DENTAL

PROVIDER 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.

Billing Provider ID#: ____________________________

☐ **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**

☐ Central California Alliance for Health

☐ Healthy Families Program

☐ HPSM Care*Advantage* (HMO)

☐ Partnership HealthPlan of CA

☐ PHC Partnership*Advantage* (HMO SNP)

☐ San Diego Neighborhood House Association

☐ San Francisco Healthy Kids

☐ San Mateo Healthy Kids

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

Provider Toll-Free: 800-838-4337
Member Toll-Free: 877-580-1042

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 Government 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. Dentist shall contact Delta Dental if an Enrollee requests or evidently requires interpretation services in any language, which services will immediately be arranged by Delta Dental at no cost to the Enrollee or 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 Dental 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 Dental 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 DENTAL'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) We will not apply contracted fees to your submitted fees for non-covered services as defined by Health & Safety Code section 1374.195(d). This definition provides that only those dental services that are never covered for any reason under a group or individual dental benefits contract are regarded as "non-covered." By contrast, procedures that are contractually limited by an annual maximum, frequency limitation or waiting period are still "covered" services, and therefore dentists can and will be held to their contracted fee for these categories of services.

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 Dental'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

7.0 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.

7.1 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).

7.2 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.

7.3 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.

DENTIST:	**DELTA DENTAL OF CALIFORNIA:**
______________________________ (Print Legal Name of Contracting Dentist, Dental Group, Dental Clinic or Public Entity)	______________________________ Print Name
______________________________ Authorized Signature	______________________________ Authorized Signature
______________________________ Print Name (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(s):

____
Street

____
City/State/Zip

____
Street

____
City/State/Zip

____
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®

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

OFFICE 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 ______________________

1. Billing Provider Information

Billing/Owner Provider Name ______________________ ☐ DDS ☐ DMD
(First) (MI) (Last)

DBA or Group/Clinic Name ______________________

License Number ______________ Tax Identification Number ______________ (*IRS document required*)

National Provider Identifier (NPI) Number ______________

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 new 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 Yes ☐ No ☐ **OR** a Specialist Yes ☐ No ☐ (*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 ☐

2. "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.

Street Address ______________________ City ______________ State ______ Zip Code ________

Telephone ______________________ FAX ______________________

3. 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*-Week(s) ________ *Routine*-Week(s) ________ *Hygiene*-Week(s) ________

Number of RDH's: Full Time ____________ Part Time ________ / ________ Number of hours per week available

Number of RDA's: Full Time ____________ Part Time ________ / ________ Number of hours per week available

Num. of other Auxiliary staff: Full Time ____________ Part Time ________ / ________ Number of hours per week available

4. Treating Provider Information: Please complete for each licensed dentist that will be providing treatment in this service office.

(For descriptions of the Provider classifications listed below, please refer to the Provider Completion Guide included with this packet)

Treating Provider Name ____________________ ☐ DDS ☐ DMD
(First) (MI) (Last)

License Number ____________________

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

Treating Provider Name ____________________ ☐ DDS ☐ DMD
(First) (MI) (Last)

License Number ____________________

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

Treating Provider Name ____________________ ☐ DDS ☐ DMD
(First) (MI) (Last)

License Number ____________________

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

Treating Provider Name ____________________ ☐ DDS ☐ DMD
(First) (MI) (Last)

License Number ____________________

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

Treating Provider Name ____________________ ☐ DDS ☐ DMD
(First) (MI) (Last)

License Number ____________________

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

Treating Provider Name ____________________ ☐ DDS ☐ DMD
(First) (MI) (Last)

License Number ____________________

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

Treating Provider Name ____________________ ☐ DDS ☐ DMD
(First) (MI) (Last)

License Number ____________________

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

CONFIDENTIAL
CREDENTIALING INFORMATION FORM

This form must be completed by the contracting dentist and each associate dentist treating enrollees. Your responses on this form will be used to determine whether you meet the eligibility criteria for participation in the network. Treating dentists must maintain eligibility throughout the term of their participation.

1. Provider Information

Last Name: ____________________ First Name: ____________________ Middle Initial: ________

Other name used: ____________________

❑ DDS ❑ DMD ❑ Other ____________ ❑ NPI Number ____________ ❑ Indicate Type ________

Date of Birth: ____________ (DOB is Mandatory) ❑ Male ❑ Female ❑ Dentist Social Security # ____________ (SS# is Mandatory here not Tax ID or NPI)

Dental School: ____________________ Year Graduated: ____________

Specialty School (if applicable): ____________________ Year Graduated: ____________

❑ General Dentist ❑ Orthodontist ❑ Oral Surgeon ❑ Prosthodontist

❑ Pedodontist ❑ Endodontist ❑ Periodontist

Are you currently Board Certified? ❑ Yes ❑ No If yes, indicate which Board ____________

List hospital for which you have privileges: (List any additional hospitals on back.)

Name: ____________________ Address: ____________________

Copies of the following documents are required - Copies must be clear, legible and current

Dental License #: ____________________ State: ________ Exp. Date ____________

DEA Certificate #: ____________________ DEA Exp. Date: ____________

Prof. Liability Ins. Co. ____________________ Policy #: ____________

Liability Limits: *(Each Claim)* ____________ *(Aggregate Claim)* ____________ Policy Exp. Date: ____________

NPI#: ____________________ *(If assigned and not previously submitted)*

Practice Name: ____________________

Practice Address: ____________________

City: ____________________ State: ____________ Zip: ____________

Contact Person: ____________________ E-mail Address: ____________________

Practice Phone Number: ____________________ Practice Fax Number: ____________________

If applicable:

Controlled Substance Certificate #: ____________________ Exp. Date: ____________

Do you contract with Medicaid and/or CHIP? ❑ Yes ❑ No

TEXAS ONLY:

TPI# (if applicable) ____________

Practice owner/managing dentist - submit current copy of X-ray Certificate of Registration.

2. Dental Work History for the Past Five Years

You must list a complete work history for the past five years including dates. Please provide an explanation of any work gaps greater than six months during the past five (5) years.

1. ______________________________ Date: ______________

2. ______________________________ Date: ______________

3. ______________________________ Date: ______________

4. ______________________________ Date: ______________

5. ______________________________ Date: ______________

3. Provider Checklist

Please note, we must receive the following documents from you in order to process your application:

- ❑ A complete copy of this form (*"Credentialing Information Form"*) for all dentists at the practice
- ❑ A copy of each dentist's current state license
- ❑ A copy of each dentist's DEA certificate
- ❑ A copy of the declaration page of each dentist's malpractice insurance
- ❑ A copy of the diploma from an accredited post graduate training identifying the specialty for each specialist as applicable
- ❑ Specialty only: If trained outside the U.S. or Canada, alternate pathways credentialing process required
- ❑ A signed copy of the enclosed form (*"Release to Produce Additional Certificate of Insurance Coverage"*) for each dentist

Date Stamp

TO EXPEDITE THE CREDENTIALING PROCESS, THIS PAGE MUST BE COMPLETED IN ITS ENTIRETY.

4. Professional Attestation and Questions

Dentist First Name (Please print)	Middle Initial	Last Name

Dentist Date of Birth	Dentist License Number	State Issuing License

I. Credentialing History (Please answer questions 1 - 10 below. For any "Yes" answer, explain on a separate piece of paper.)

Yes No

❑ ❑ 1. Has your license to practice in any jurisdiction, whether past or still pending, been denied, restricted, limited, suspended, revoked, not renewed, placed under probation, subjected to disciplinary action, or otherwise sanctioned, limited or curtailed?

❑ ❑ 2. Has your professional liability insurance ever been denied, suspended, revoked, canceled, or not renewed?

❑ ❑ 3. Has your Federal and/or State DEA license or applicable drug license ever been denied, suspended, canceled or not renewed, or subjected to any disciplinary action?

❑ ❑ 4. Has your status as a provider ever been denied, suspended, canceled or sanctioned by any municipal, state, federal or any other governmental agency (e.g. Medicare, Medicaid or Denti-Cal) HMO, EPO, PPO or other prepaid health plan?

❑ ❑ 5. Are your privileges or memberships at any hospital, institution (Military service) and/or HMO currently under investigation or have they ever been denied, suspended, reduced or not renewed?

❑ ❑ 6. Have you ever been denied membership, or renewal of membership, or been subject to disciplinary proceedings for a medical, dental or ethical reason by any dental/professional organization?

❑ ❑ 7. Are you unable to perform any procedures within the scope of privileges and duties in your position as a health care provider, with or without reasonable accommodations required by the Americans With Disabilities Act, within accepted standards of professional performance and without posing a direct threat to patients?

❑ ❑ 8. Do you currently, or did you in the last five years, engage in the unlawful use of illegal drugs, including the improper use of prescription drugs?

❑ ❑ 9. Do you have any felony or misdemeanor charges pending against you or have you ever been convicted of a felony, or pleaded "nolo contendere" to a felony?

❑ ❑ 10. Have you been involved in ANY malpractice (or any other civil) claims/lawsuits, settlements or judgments within the last **five years**? **If yes, please provide detailed information on a separate sheet of paper including: docket number of the case, location of the court, names of the parties, plaintiff(s) and defendant(s), dates of the incident(s), description of the incident(s), your involvement, current disposition, and the amount of the settlement(s).**

II. Compliance & Malpractice Insurance (Answer questions 11, 12 and 13. For any "NO" answer, explain on a separate sheet of paper.)

No Yes

❑ ❑ 11. Do you observe all applicable laws and regulations related to the practice of dentistry including, but not limited to, those dealing with infection control and employee safety in the work place?

❑ ❑ 12. Do you have current professional malpractice insurance coverage and agree to maintain continuous, uninterrupted coverage while either a contracted dental provider for the Plan or an associate of a contracted dental provider? Please note that under the terms of participation that you further agree to notify the Plan immediately of any policy cancellation, lapse in coverage, reduction in coverage maximum(s) or claims made.

❑ ❑ 13. Is practice accepting new patients?

I authorize the Plan to consult with professional liability carriers, and other persons or entities to obtain information concerning my professional qualifications including competence, ethics and other qualifications. I, the undersigned, hereby certify that the information requested by the Plan and provided herein, is truthful, correct and complete in all respects. I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for denying participation or termination as a participating dentist with the dental plan. The undersigned hereby agrees to notify the Plan immediately of any changes in the above information.

Dentist Signature (no signature stamps): ______________________ Date: ______________

Release to Produce

Additional Certificate of Insurance Coverage

I hereby request that ____, from which I purchase my liability insurance, is authorized to produce an additional certificate of insurance coverage for the Provider Administration Department, 1130 Sanctuary Parkway, Suite 600, Alpharetta, GA 30009. This certificate can be mailed at each renewal until otherwise notified.

Doctor Signature	Date	Policy Number
Print Name	Date	License Number

DELTA DENTAL®

Taxpayer Identification Number (TIN) Enrollment Form

The IRS requires the following information for income reporting purposes. Please resubmit this form any time your enrollment changes (e.g., you enter a new partnership or are issued a new taxpayer identification number).

Please fill out form completely.

1) **Taxpayer Identification Number** ____________________

2) License Number ____________________

3) Dentist's Name ____________________

4) **Name of the person, partnership or business in which the above TIN (item #1) was issued by the IRS.**

____

If two or more names are used (such as Chris Jones, DDS, dba Main Street Dental), please report the first of the names (Chris Jones, DDS) to Delta.

5) Office Location

Office Address: ____________________

City ____________________, CA ZIP ____________________

Phone # (   ) ____________________

6) Mailing Address (if different from office location): ____________________

City ____________________, CA ZIP ____________________

Phone # (   ) ____________________

7) Type of Business Entity ☐ Individual/ Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other (please specify) ____________________

8) I certify under penalty of perjury that the Tax Identification Number and Name I have provided is correct.

____________________ Signature

____________________ Date

Please return this form to: Delta Dental of California
ATTN: Dentist Network Administration and Contracting
P.O. Box 537010
Sacramento, CA 95853-7010
Or via Fax: 916-852-8995

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®

DIRECT DEPOSIT ENROLLMENT FORM

☐ New enrollment ☐ Change enrollment information ☐ Discontinue enrollment

Business Information	
Owner(s) full name	
Registered IRS name	
Tax Identification Number (TIN)	
Business National Provider Identifier (NPI)	

Practice Location 1	
Practice location name - Doing Business As (DBA)	
Street address	
City	
State	
ZIP	

Practice Location 2	
Practice location name - Doing Business As (DBA)	
Street address	
City	
State	
ZIP	

- This enrollment form will apply to all providers within the same Tax Identification Number (TIN) and practice location.
- If this enrollment form applies to three or more locations, please attach a separate sheet listing all additional locations.
- This form will also be applicable to payments issued under our Community Partnership Programs, Texas CHIP, Delta Dental Premier® and Delta Dental PPO℠ plans. Direct deposit will be made to one bank account for all lines of business if they share the same TIN and practice location.

Banking Information	
Type of account	☐ Checking ☐ Savings
Name shown on the bank account record	
Bank routing number (nine digits noted on check)	☐☐☐☐☐☐☐☐☐
Bank account number	
NOTE: A photocopy of a VOIDED check must be returned with this signed enrollment form.	

Discontinue enrollment:

Reason for discontinuing enrollment: ____________________

Contact name: ____________________ Telephone number: (_____)____________________

Please indicate your email address below if you would like to receive an email confirmation after this enrollment form has been processed: ____________________

____________________ Date: ____________________

Provider's signature (Requires provider's original signature)

#65283 (8/11)

Completion of the Direct Deposit Enrollment Form

Please be sure the information on this form is accurate and complete to help prevent any unnecessary delays in processing your request. Before submitting your enrollment form, please check that you have:

Checked "*New Enrollment*," "*Change Enrollment Information*" or "*Discontinue Enrollment*."

Filled in your business and practice location information.

Filled in your banking information and attached a photocopy of a VOIDED check with the form.

For discontinuing enrollment only: Filled in your reason(s) for discontinuing enrollment.

Provided your contact information so that we may clarify any statements or data on the form if necessary.

Signed and dated the form. The provider's actual signature is required. Rubber stamped signatures or initials cannot be accepted.

Reminder: Please notify Delta Dental immediately if there are any changes to the information you have submitted on this form.

Delta Dental includes these companies in these states:
Delta Dental of California - CA, Delta Dental of Pennsylvania - PA & MD, Delta Dental of West Virginia - WV, Delta Dental of Delaware, Inc. - DE, Delta Dental of the District of Columbia, Inc. - DC, Delta Dental of New York, Inc. - NY, Delta Dental Insurance Company - AL, FL, GA, LA, MS, MT, NV, TX, UT.

DELTA DENTAL

PROVIDER COMPLETION GUIDE

Provider classification descriptions:

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.

IMPORTANT: Please return the following (the documents listed below are in addition to the documents requested in section 3 of the Credentialing Information Form):

- ☐ Directory Selection List
- ☐ The Original, inked signature (no copies) of the billing provider, CEO or director on the *Provider Agreement* (page 8 of the contract)
- ☐ Appendix B *(if applicable)*
- ☐ Office Profile Form
- ☐ Taxpayer Identification Number (TIN) Enrollment Form
- ☐ Direct Deposit Form *(if applicable)*

Also include the following:

- ☐ Curriculum Vital (academic history) for ***each*** treating provider **(PCD Providers Only)**
- ☐ Copy of current CPR (cardiopulmonary resuscitation) certificate for ***each*** treating provider **(PCD Providers Only)**
- ☐ Copy of current permit if General Anesthesia OR Conscious Sedation is administered in the practice *(if applicable)*
- ☐ Copy of current, valid, legible 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

If you have any questions, please call us at 800-838-4337.