

Dear Doctor:

Enclosed please find the documents and information you requested regarding Texas CHIP Dental Services. Texas CHIP provides medical and dental benefits to over 500,000 children in Texas whose family income is above the federal poverty level but who do not qualify for Medicaid and cannot afford private insurance.

Your office can help deserving children receive appropriate dental care by contracting as a CHIP network dentist. The dental benefits include diagnostic and preventive care as well as therapeutic services such as fillings, laboratory processed crowns, root canals and extractions. Benefits are payable only when the child is treated by a contracted dentist and payment will be made by Delta Dental directly to the treating dentist.

There is an annual maximum allowance that will apply to Texas CHIP dental benefits. Preventive benefits will have a \$250 maximum for a 12-month period. The annual maximum for therapeutic services will be administered in a three-tiered progressive approach based upon the number of years the patient has been enrolled in the program. The three tiers are:

- Tier I: Preventive services plus up to \$280 of therapeutic services.
- Tier II: Preventive services plus up to \$425 of therapeutic services.
- Tier III: Preventive services plus up to \$565 of therapeutic services.

Preventive or therapeutic services that are provided after the patient has exhausted the applicable annual maximum may be charged directly to the enrollee.

If you are interested in contracting as a CHIP network dentist, simply complete the enclosed network enrollment materials, including the Texas CHIP Dental Services Contracting Dentist Agreement and return to:

Texas CHIP Dental Services  
Delta Dental State Government Programs  
P.O. Box 537014  
Sacramento, CA 95853-7014

You can find additional information regarding participating in Texas CHIP Dental Services, including a copy of the Texas CHIP Provider Manual, on our website at <http://www.deltadentalins.com/tchip>.

We hope you will consider contracting as a dentist with this important program. Delta Dental looks forward to partnering with your office to help Texas children receive the dental care they deserve.

Sincerely,

DELTA DENTAL



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

## TEXAS CHIP DENTAL SERVICES CONTRACTING DENTIST AGREEMENT

Delta Dental Insurance Company (“DDIC”) underwrites and/or administers various dental care programs covering eligible patients located in the State of Texas and in particular, the dental plan for the Texas Children’s Health Insurance Program (“CHIP Dental Plan”). The undersigned dentist desires to become a Contracting Dentist for the CHIP Dental Plan and to be listed as a Contracting Dentist in any directories published for the CHIP Dental Plan.

1. Contracting Dentist agrees:
  - a. to provide to eligible enrollees of the CHIP Dental Plan dentally necessary and appropriate Covered Dental Services, as defined in Delta Dental’s CHIP Provider Manual and any updates thereto, a copy of which will be provided to Contracted Dentist and the terms of which are incorporated herein by this reference as if they are set forth at length.
  - b. to abide by all DDIC procedures and policies adopted to administer the CHIP Dental Plan, provided that the Contracting Dentist is given reasonable advance notice of such procedures and policies.
  - c. to ensure that Covered Dental Services are available to CHIP Dental Plan enrollees in a manner that is both timely and appropriate for the patient’s dental needs and, at a minimum, to meet the standards for emergency, urgent, routine and follow-up care as set forth in the CHIP Provider Manual.
  - d. to charge eligible enrollees no more than the attached Fee Schedule for Covered Dental Services that are payable by DDIC.
  - e. to submit Attending Dentist’s Statements on behalf of CHIP Dental Plan enrollees for the purpose of obtaining payment or authorization for services.
  - f. to enter on each Attending Dentist’s Statement his/her usual fee charged or to be charged for Covered Dental Services provided and to be responsible for the accuracy of all information shown on any Attending Dentist’s Statement submitted.
  - g. to be bound by the determination of the amount payable by DDIC for Covered Dental Services. Contracting Dentist may bill the patient for non-covered dental services and/or any amounts in excess of the patient’s annual maximum benefits, but Contracting Dentist agrees not to bill the patient under any circumstances for that portion of Covered Dental Services that is the responsibility of DDIC.
  - h. to allow DDIC or its representatives access at reasonable times to the records of Contracting Dentist relating to Covered Dental Services provided to CHIP Dental Plan enrollees, the cost of such services, and the payment received for such services.
  - i. to cooperate with local review committees or consultants designated by DDIC for the purpose of reviewing the adequacy of care provided by Contracting Dentist to patients covered by CHIP Dental Plan.
  - j. to cooperate with and abide by decisions arising from the Enrollee Complaint and Grievance Procedures established by DDIC pursuant to CHIP requirements and as set forth in the CHIP Provider Manual.
  - k. to comply with the standards and requirements of the Quality Management Program as established by DDIC in accordance with CHIP requirements and as set forth in the CHIP Provider Manual. The Quality Management Program shall include but not be limited to policies and procedures for credentialing, re-credentialing, dental office audits, and peer review.
  - l. to submit all patient dental claim forms according to the requirements set forth in the CHIP Provider Manual. All fee-for-service payments shall be subject to Delta Dental’s review and approval of services provided as being within the scope of Covered Dental Services and dentally necessary according to criteria set forth in the CHIP Provider Manual.
  - m. to cooperate fully with the Texas State Auditor’s Office (“SAO”), or any successor agency, in the conduct of the audit or investigation, including providing all records requested. Contracted Dentist understands and agrees that the acceptance of funds under this agreement acts as acceptance of the authority of the SAO to conduct an investigation in connection with those funds.
2. Delta Dental agrees:
  - a. to confirm eligibility and authorize Covered Dental Services as set forth in the CHIP Provider Manual.
  - b. to pay Contracted Dentist for Covered Dental Services provided in accordance with the attached Fee Schedule.

- c. to make available to Contracted Dentist the Provider Manual describing DDIC's general policies and procedures and the policies and procedures of the CHIP Dental Plan. The Provider Manual may be updated by DDIC on a periodic basis.
- 3. DDIC may deny payment of a claim for Covered Dental Services submitted more than twelve (12) months after the date the services were provided and DDIC may recover any amount owed to it by Contracting Dentist by deducting such amounts from subsequent amounts payable to Contracting Dentist.
- 4. Contracting Dentist may terminate this agreement by giving written notice to DDIC at any time. Such termination shall become effective 30 days from DDIC's receipt of written notice. DDIC may terminate this agreement for cause by giving Contracting Dentist written notice of the reason for such termination. DDIC shall not accept a new Contracting Dentist Agreement for a period of at least 12 months following termination of a prior Contracting Dentist Agreement. For a period of one year following termination of this agreement for any reason, Contracting Dentist agrees to advise eligible CHIP patients that he/she is no longer a Contracting Dentist.
- 5. The terms and conditions of this agreement shall only apply to those Enrollees in the CHIP Dental Plan and shall not affect patients under any other group dental contracts or policies with DDIC.
- 6. This agreement shall be governed, construed and enforced in accordance with the laws of the State of Texas.
- 7. Any provisions required to be included in this agreement by state or federal law or by government agencies with jurisdiction over DDIC shall bind DDIC and Contracted Dentist whether or not expressly provided in this agreement.

**In Witness Whereof**, the undersigned have executed this Agreement to be effective as of the Contract Effective Date written below:

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

**DELTA DENTAL INSURANCE COMPANY**

\_\_\_\_\_  
 Authorized Signature

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Print Name and Title (if applicable) of person signing

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Tax Identification Number

\_\_\_\_\_  
 Contract Effective Date

\_\_\_\_\_  
 National Provider Identifier

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

\_\_\_\_\_  
 Contracting Office Location

\_\_\_\_\_  
 Street

\_\_\_\_\_  
 City/State/ZIP

## TEXAS CHIP OFFICE PROFILE

### Billing Provider Information

Billing Provider Name \_\_\_\_\_ DDS DMD (circle one)

DBA or Group/Clinic Name \_\_\_\_\_

License Number \_\_\_\_\_ Group or Business NPI Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email address \_\_\_\_\_

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

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

List practice limitations \_\_\_\_\_

### "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 \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Accessibility

Hours of Operation: (example: 9-6 or 8:30-5)

Monday      Tuesday      Wednesday      Thursday      Friday      Saturday      Sunday

\_\_\_\_\_

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? \_\_\_\_\_

List any special features of your office (e.g. transportation assistance, American Sign Language, etc.) \_\_\_\_\_

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)

# 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: \_\_\_\_\_  Male  Female  Dentist Social Security # \_\_\_\_\_  
(DOB is Mandatory)  (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

## DIRECT DEPOSIT ENROLLMENT FORM

New enrollment     
  Change enrollment information     
  Discontinue enrollment

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

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

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

- 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<sup>SM</sup> 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											
<b>Type of account</b>	<input type="checkbox"/> Checking <input type="checkbox"/> Savings										
<b>Name shown on the bank account record</b>											
<b>Bank routing number</b> (nine digits noted on check)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
<b>Bank account number</b>											
<b>NOTE:</b> 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)

## 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.

Send via U.S. mail, fax or scan and email the completed form and voided check to:

Delta Dental of California  
Attn: Dentist Network Administration and Contracting  
100 First Street, M/S 5S  
San Francisco, CA 94105  
**Prov\_EFT@delta.org**  
**Fax: 415-975-8275**

**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.*

## Request for Taxpayer Identification Number and Certification

**Give form to the  
 requester. Do not  
 send to the IRS.**

<b>Print or type See Specific Instructions on page 2</b>	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ .....	
	<input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code		
List account number(s) here (optional)		

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

<b>Social security number</b>									

**or**

<b>Employer identification number</b>									

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or

- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.**

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

## 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 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.

## Specific Instructions

### Name

If you are an individual, you must generally enter 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, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

**Other entities.** Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

**Exempt payees.** Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
2. The United States or any of its agencies or instrumentalities,
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

- 7. A foreign central bank of issue,
- 8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
- 9. A futures commission merchant registered with the Commodity Futures Trading Commission,
- 10. A real estate investment trust,
- 11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
- 12. A common trust fund operated by a bank under section 584(a),
- 13. A financial institution,
- 14. A middleman known in the investment community as a nominee or custodian, or
- 15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt recipients 1 through 7 <sup>2</sup>

<sup>1</sup>See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup> However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.socialsecurity.gov/online/ss-5.pdf](http://www.socialsecurity.gov/online/ss-5.pdf). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses/](http://www.irs.gov/businesses/) and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting [www.irs.gov](http://www.irs.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

## What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>1</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or single-owner LLC	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Sole proprietorship or single-owner LLC	The owner <sup>3</sup>
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

## Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.



## **TEXAS CHIP DENTAL SERVICES COMPLETION GUIDE/CHECKLIST**

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

- Participating Dentist Agreement
  - Please sign and date the agreement (original inked signature)
  - List all associate(s) in your practice
- Office Profile Form
- Direct Deposit Form (if applicable)
- W-9 Form
  - If the associate used a different TIN, attach a separate W-9
  - Please provide your TIN issued by the Social Security Administration or EIN issued by the Internal Revenue Service. Please indicate the legal business name only “*Doing business as*” will not be accepted
- Practicing Dentist(s) Information Form

If you should have questions regarding these requests, please contact our Provider Call Center’s toll-free telephone number at 866-561-5891.

Please mail the completed packet to:

**Delta Dental of California  
State Government Programs  
P.O. Box 537014  
Sacramento, CA 95853-7014**

On the following page, please list the names of all dentists who are practicing in your office and list their state board license number and specialty.

## Practicing Dentist(s) Information Page

Please list each location under your tax identification number where the dentist(s) are practicing. All dentists practicing under the owning or managing dentist's tax identification number at the listed location(s) will also be contracted with Delta Dental.

<b><u>Owning/Managing Dentist Name</u></b>	<b>License #</b>	<b>Specialty</b>
_____	_____	_____
<b>Location</b>		<b>Phone</b>
_____		_____

<b><u>Associate Name</u></b>	<b>License #</b>	<b>Specialty</b>
_____	_____	_____
<b>Location</b>		<b>Phone</b>
_____		_____

<b><u>Associate Name</u></b>	<b>License #</b>	<b>Specialty</b>
_____	_____	_____
<b>Location</b>		<b>Phone</b>
_____		_____

<b><u>Associate Name</u></b>	<b>License #</b>	<b>Specialty</b>
_____	_____	_____
<b>Location</b>		<b>Phone</b>
_____		_____

<b><u>Associate Name</u></b>	<b>License #</b>	<b>Specialty</b>
_____	_____	_____
<b>Location</b>		<b>Phone</b>
_____		_____

Thank you for your cooperation. Your timely submittal of these items sets you on the path to experience The Delta Dental Difference<sup>SM</sup>.

# Delta Dental CONFIDENTIAL Schedule of Maximum Allowances (SMA)

Texas CHIP Dental Services		TX01
CDT 11	<u>Description of Service (text in Italics is not part of CDT nomenclature)</u>	Maximum Allowable Charge
<b>PREVENTIVE SERVICES (All preventive services limited to \$250 per year)</b>		
D0120	periodic oral evaluation	\$28.85
D0140	limited oral evaluation	\$24.50
D0150	comprehensive oral evaluation (initial) - <i>(Limited to one per child's lifetime per dentist)</i>	\$35.32
<b>RADIOGRAPHS/DIAGNOSTIC IMAGING</b>		
D0210	intraoral - complete series (including bitewings) - <i>(Limited to one per 36 months)</i>	\$70.65
D0220	intraoral - periapical first film	\$12.56
D0230	intraoral - periapical each additional film	\$11.51
D0270	bitewing - single film	\$7.84
D0272	bitewings - two films	\$23.39
D0274	bitewings - four films	\$34.62
D0330	panoramic film - <i>(Limited to one panoramic film for age 5 through 9 and one panoramic film for age 10 through 18. Limited to one per 5 years)</i>	\$63.78
<b>CLEANINGS</b>		
D1110	prophylaxis (cleaning) - <i>age 13 through 18</i>	\$54.89
D1120	prophylaxis (cleaning) - <i>age 1 through 12</i>	\$36.75
D1351	sealant - per tooth - <i>(Limited to one per tooth, per lifetime (permanent molars and maxillary pre-molars only))</i>	\$28.25
<b>THERAPEUTIC SERVICES (All therapeutic services include any required local and topical anesthetics)</b>		
<b>AMALGAM (SILVER FILLINGS) (All amalgam fillings are limited to one tooth per 12 months)</b>		
D2140	amalgam - one surface, primary	\$60.75
D2140	amalgam - one surface, permanent	\$64.41
D2150	amalgam - two surfaces, primary	\$81.25
D2150	amalgam - two surfaces, permanent	\$85.72
D2160	amalgam - three surfaces, primary	\$88.22
D2160	amalgam - three surfaces, permanent	\$109.20
D2161	amalgam - four or more surfaces, primary or permanent	\$75.47
<b>RESIN FILLINGS (WHITE FILLINGS) (All resin-based fillings are limited to one per tooth per 12 months)</b>		
D2330	resin-based composite - one surface, anterior	\$77.76
D2331	resin-based composite - two surfaces, anterior	\$103.05
D2332	resin-based composite - three surfaces, anterior	\$134.55
D2335	resin-based composite - four or more surfaces or involving incisal angle	\$166.99
D2391	resin-based composite - one surface, posterior (primary)	\$75.45
D2391	resin-based composite - one surface, posterior (permanent)	\$82.41
D2392	resin-based composite - two surfaces, posterior (primary)	\$97.01
D2392	resin-based composite - two surfaces, posterior (permanent)	\$108.01
D2393	resin-based composite - three or more surfaces, posterior (primary)	\$109.77
D2393	resin-based composite - three or more surfaces, posterior (permanent)	\$109.77
D2394	resin-based composite - four or more surfaces, posterior	\$117.61
<b>CROWNS (CAPS) (All crowns are limited to one per tooth per 5 years)</b>		
D2710	crown - resin, <i>laboratory</i>	\$258.75
D2720	crown - resin with high noble metal	\$425.36
D2721	crown - resin with predominantly base metal	\$352.84

## Delta Dental CONFIDENTIAL Schedule of Maximum Allowances (SMA)

Texas CHIP Dental Services		TX01
<b>CDT 11</b>	<b>Description of Service (text in Italics is not part of CDT nomenclature)</b>	Maximum Allowable Charge
D2722	crown - resin with noble metal	\$392.04
D2740	crown - porcelain/ceramic substrate	\$504.75
D2750	crown - porcelain fused to high noble metal	\$517.49
D2751	crown - porcelain fused to predominantly base metal	\$517.49
D2752	crown - porcelain fused to noble metal	\$517.49
D2790	crown - full cast high noble metal	\$517.49
D2791	crown - full cast predominantly base metal	\$416.54
<b><u>OTHER RESTORATIVE SERVICES</u></b>		
D2930	prefabricated stainless steel crown - primary tooth ( <i>Limited to one per tooth per lifetime</i> )	\$152.95
D2931	prefabricated stainless steel crown - permanent tooth ( <i>Limited to one per tooth per lifetime</i> )	\$159.27
<b><u>PULPOTOMY/PULPECTOMY</u></b>		
D3220	therapeutic pulpotomy (excluding final restoration)	\$86.21
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$107.81
D3240	pulpal therapy (resorbable filling) - (excluding final restoration, posterior first and second molars)	\$147.02
<b><u>ROOT CANALS (All root canals are limited to one per tooth per lifetime)</u></b>		
D3310	endodontic therapy - anterior tooth (excluding final restoration)	\$348.90
D3320	endodontic therapy - bicuspid tooth (excluding final restoration)	\$404.29
D3330	endodontic therapy - molar tooth (excluding final restoration)	\$611.84
<b><u>EXTRACTIONS (TOOTH REMOVAL)</u></b>		
D7140	extraction - erupted tooth or exposed root (elevation and/or forceps removal)	\$65.71
<b><u>SURGICAL EXTRACTIONS</u></b>		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$100.76
D7220	removal of impacted tooth - soft tissue	\$154.37
D7230	removal of impacted tooth - partially bony	\$176.42
D7240	removal of impacted tooth - completely bony	\$294.03

## **CLAIM SUBMISSION REQUIREMENTS**

Contracting Texas CHIP Dental Services dentists agree to complete and submit standard claim forms on behalf of their Texas CHIP patients and to do so without charge to the patient or Delta Dental. While dental offices may use any claim form, some earlier versions of the ADA form and accessed by other means, do not contain all required elements for processing your claims. To ensure accurate processing and prompt payment of your claims, we suggest that you consider using the current version of the standard ADA form or you may download an up-to-date SGP claim form from our website at [deltadentalins.com/tchip](http://deltadentalins.com/tchip).

## **PROVIDER CALL CENTER - GENERAL TELEPHONE INFORMATION**

Dental offices may contact Delta Dental toll-free at 866-561-5891 for information or inquiries regarding participating in CHIP, member eligibility, claims history, annual maximums, claims processing, criteria and submission requirements for covered dental services. In addition, contracting dental offices are able to access free telephonic and face-to-face interpreting services, at any time, by contacting Delta Dental. The Provider Call Center toll-free lines are available Monday through Friday from 8:00 am - 7:00 pm, except certain holidays.

When calling our Provider Call Center, callers have the option of obtaining information through our easy to use Interactive Voice Response System (IVR). Information available through the IVR includes Delta Dental's mailing address, member eligibility information such as effective dates of coverage, tier level, maximum remaining, and financial information. This information can be sent to a dental office via fax upon request. The IVR is available Monday through Friday from 7:00 am - 9:00 pm and on Saturdays from 10:00 am - 2:00 pm.

## **MEMBER CALL CENTER - GENERAL TELEPHONE INFORMATION**

If your office receives inquiries from CHIP members regarding the program, please refer them to the Member Call Center toll-free number at 866-561-5892. The Member Call Center toll-free lines are also available from 8:00 am - 7:00 pm Monday through Friday, except holidays. We also offer a toll-free number for the hearing impaired at 800-735-2922.

Either members or their authorized representatives may use this toll-free number. Member representatives must have the member's name, Texas CHIP Dental Services Identification number and date of birth in order to receive information from Delta Dental.

## **COMPLAINTS**

Complaint forms are available by contacting our Provider Call Center at 866-561-5891 or are available on our website at [deltadentalins.com/tchip](http://deltadentalins.com/tchip). Delta Dental will acknowledge a written complaint within 5 working days of receipt. Delta Dental will resolve the complaint within 30 days. Emergency complaints (involving serious and imminent threat to patient's health) will be assigned highest priority to be expedited and resolved within one day.

The resolution letter will:

1. Explain the resolution of the complaint;
2. State the specific dental and contractual reasons for the resolution;
3. State the specialization of any dentist or other provider consulted; and
4. Include a complete description of the process for complaints, including the deadlines for the complaint process and the deadlines for the final decision on the complaint.

## **APPEALS**

In the event a complainant is not satisfied with our resolution of a complaint, other than issues relating to a member's annual maximum or eligibility information provided to Delta Dental by Texas HHSC or its designee, he/she will have the right to appeal the decision before an appeal panel. A letter acknowledging the appeal will be sent within 5 business days of the date of receipt of the appeal request and include information on the appeal process and a statement of the complainant's rights.

The appeal will be resolved within 30 calendar days. The resolution of appeals involving ongoing emergency dental services will be concluded in accordance with the dental immediacy of the case, but no later than 24 hours after receipt of request for appeal. Notice of our final decision will include a statement of the specific clinical and/or Contract provision(s) on which the decision was based, and the toll-free telephone number and address of the Texas Department of Insurance.

You can file a complaint with the Texas Department of Insurance (TDI) at any time. Contact them at:

Mailing address: Texas Department of Insurance  
P.O. Box 149091  
Austin, Texas 78714-9091

Toll-free telephone number: 800-252-3439

Website: [www.tdi.state.tx.us](http://www.tdi.state.tx.us) (for instructions and complaint forms)

E-mail: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)