Simple Steps to Join LIBERTY Dental Plan's Network of Providers

- ❑ Facility Application
  (One per location)
- ❑ Provider Agreement
  (Must be signed by authorized signatory – Owner, CEO, VP, etc.)
- ❑ Medicaid and/ or Medicare Addenda (if applicable)
- ❑ Fee Schedule Addenda
- ❑ W-9
  (Must use the address registered with the IRS as your corporate billing address for multiple locations with the same tax ID #)
- ❑ Provider Credentialing Application
  One credentialing application must be completed and signed for each Dentist rendering services, along with the following:
  - Dental license
  - Current federal DEA certificate (if applicable)
  - Current malpractice insurance certificate declaration page showing professional liability
  - Copy of specialty certificate
  - Copy of internship/residency/fellowship certificate (if applicable)
  - Copy of Board Certification (if applicable)

***** Please note that certain states require a state specific mandated credentialing application.***

The items listed above are required and must accompany this application. Failure to do so may delay the processing of your application.

If you have any questions regarding the contracting process, please contact Professional Relations at (888) 700-0643.

FACILITY APPLICATION *(Complete one application per facility)*

Facility Information

LEGAL ENTITY: ☐ Corporation ☐ Partnership ☐ Individual / Sole Proprietor

PRACTICE NAME (DBA): ____________________

PRACTICE ADDRESS: ____________________
Street Address *Suite/Unit #*
____
City *State* *Zip* *County*

TELEPHONE #: (   ) ____________ **Fax #:** (   ) ____________

EMERGENCY #: ____________ **EMAIL ADDRESS:** ____________

INDIVIDUAL NPI #: ____________ **ORGANIZATIONAL NPI #:** ____________
(if applicable)

TAX PAYOR IDENTIFICATION (TIN): ____________ **PRACTICE CONTACT:** ____________

MAILING ADDRESS**:** ____________________
(if different from above) *Street Address* *Suite/Unit #*
____
City *State* *ZIP Code*

LANGUAGES SPOKEN: ____________________

RECALL METHOD USED: ____________________

PRIMARY DENTIST: ____________ ☐**DDS** ☐ **DMD** ☐**Other (specify)** ________

ASSOCIATE DENTIST: ____________ ☐**DDS** ☐ **DMD** ☐**Other (specify)** ________

ASSOCIATE DENTIST: ____________ ☐**DDS** ☐ **DMD** ☐**Other (specify)** ________

ASSOCIATE DENTIST: ____________ ☐**DDS** ☐ **DMD** ☐**Other (specify)** ________

(Attach list with additional Associates if necessary)

Please check if this facility is designated as any one of the following:

☐ **(FQHC)** Federally Qualified Health Center
☐ **(CHC)** Community Health Center
☐ **(IHS)** Indian Health Services
☐ **(RHC)** Rural Health Clinic

Accessibility

Does this facility have a 24 hour emergency contact system? ☐ **Yes** ☐ **No**

What type of emergency contact system is used? ____________________

Is this facility wheelchair accessible? ☐ **Yes** ☐ **No**

Age range of patients seen? ☐ **0 - 99+** ☐ **0 - 21** ☐ **Other:** ____________

Hours of Operation

Day				
Monday		AM		PM
Tuesday		AM		PM
Wednesday		AM		PM
Thursday		AM		PM
Friday		AM		PM
Saturday		AM		PM
Sunday		AM		PM

Appointment Wait Times

Initial ________ **weeks**

Hygiene ________ **weeks**

Routine ________ **weeks**

Lobby Wait Time ________ **minutes**

LIBERTY DENTAL PLAN | PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT (the "Agreement") is made and entered into by and between **LIBERTY Dental Plan Corporation** (collectively with any affiliates, subsidiaries and parent corporations, and as defined below, "LIBERTY") and [LEGAL NAME OF DENTAL OFFICE]: ____ ("Dental Office"), a [CHECK ONE]: □ *individual practice* □ *partnership* □ *professional corporation* □ *other*: ___________________________________, effective as of the date specified by LIBERTY on the signature page (the "Effective Date"). LIBERTY and Dental Office may each be referred to as a "Party" and together, may be referred to as the "Parties."

RECITALS

WHEREAS, LIBERTY desires to make contractual arrangements for its Members (hereinafter defined) under which Dental Office (hereinafter defined) agrees to furnish dental and related services to Members;

WHEREAS, Dental Office is willing to enter into this Agreement with LIBERTY and furnish dental and related services to Members of LIBERTY upon the terms and conditions herein contained;

NOW, THEREFORE, in consideration of the covenants and agreements contained herein, and for all other good and valuable consideration had and received, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

DEFINITIONS

"Clean Claim" means a claim which can be processed immediately and meets all applicable requirements set forth in LIBERTY's provider manual and/or administrative guidelines or in any applicable addendum or exhibit.

"Continuity of Care" means the obligation of LIBERTY to continue to reimburse a provider for services, which would have been Covered Services had the Agreement not been terminated, provided to a Member beyond the termination date where certain "Special Circumstances," as defined herein, are present. Special Circumstances means a condition in which the treating provider reasonably believes that discontinuing care by the provider could cause harm to a Member who has a special circumstance, including a Member with a disability, acute condition, life threatening illness, or who is past the twenty-forth (24th) week of pregnancy.

"Cost Sharing" means any applicable Member coinsurance, copayment or deductible as set forth in the applicable Plan Description.

"Covered Services" means medically necessary and appropriate dental benefits, services, treatment and supplies that the Member is entitled to receive under the applicable Dental Plan, as set forth in the Plan Description.

"Dental Director" means the individual or group of individuals appointed by LIBERTY to maintain professional standards for the dentists contracting with LIBERTY.

"Dental Office" means the individual dentist or dental practice (whether a partnership, professional corporation or other business entity) named in the above preamble and on the signature page of this Agreement. As further described in Section 1.2 ("Dental Office Agents"), "Dental Office" shall be construed to include, with respect to all restrictions upon and obligations of Dental Office under this Agreement, all dentists of Dental Office that have been contracted, or approved by, LIBERTY. Only those Dental Office locations and Dental Office dentists approved by LIBERTY shall be able to perform services under this Agreement and be eligible for compensation hereunder.

"Dental Plan(s)" means the applicable plan(s) outlining terms of coverage as provided by LIBERTY.

"LIBERTY" means LIBERTY Dental Plan Corporation unless otherwise specified by LIBERTY. If pursuant to this Agreement Dental Office is obligated to render Covered Services to Members in a state in which LIBERTY Dental Plan Corporation is not appropriately qualified to contract with providers, this Agreement shall then be construed to apply to the LIBERTY entity (whether a subsidiary or affiliate of LIBERTY Dental Plan Corporation) duly qualified to so contract. Such entity may be specifically identified by LIBERTY in any state-specific addendum or exhibit to this agreement. Dental Office acknowledges and agrees that in such a case, all of LIBERTY's obligations under this agreement shall apply only to such LIBERTY entity.

"Member" means an individual enrolled in the Dental Plan(s).

"Plan Description" means the evidence of coverage and summary of benefits issued to Member by LIBERTY that describes Covered Services, exclusions and limitations, and Cost Sharing.

ARTICLE I: RELATIONSHIP OF THE PARTIES

1.1 Independent Contractors. LIBERTY and Dental Office are separate and independent entities. Dental Office shall be deemed an independent contractor, and not an employee, agent, joint venturer or partner of LIBERTY, within the meaning of all federal, state and local laws and regulations governing employment insurance, workers' compensation, labor and taxes and any other applicable laws and regulations. Nothing in this Agreement, nor any act or conduct by LIBERTY, shall be interpreted or construed as making Dental Office or any Dental Office Agents an agent, partner or joint venture or LIBERTY or as creating or establishing an employer-employee relationship between LIBERTY and Dental Office (or Dental Office Agents). LIBERTY shall not be liable for withholding taxes respecting Dental Office. For tax purposes, Dental Office shall, as LIBERTY deems necessary, receive a Form 1099 or other appropriate tax-related documents and Dental Office shall be responsible for its own taxes associated with its performance of the services hereunder and receipt of payments pursuant to this Agreement. Dental Office shall not, by reason of this Agreement, acquire any benefits, privileges or rights under any benefit plan operated by LIBERTY for the benefit of its employees, including, without limitation, any pension or profit-sharing plans or any plans, coverages or benefits providing workers' compensation, medical, dental, disability or life insurance protection. Dental Office agrees and acknowledges that Dental Office is not authorized to enter into any contract or assume any obligation on behalf of LIBERTY without the prior written consent of LIBERTY. The Parties acknowledge and agree that Dental Office shall be solely responsible for dental advice and the provision of services (or failure to provide services) to Members and that LIBERTY shall not be liable for any act or omission by Dental Office or by Dental Office Agents.

1.2 Dental Office Agents. All of the restrictions on and obligations of Dental Office set forth in this Agreement shall equally apply to any dentist of Dental Office performing services under this Agreement and to any employee or assistant (or any other person acting at the direction or under the control) of Dental Office (collectively, "Dental Office Agents"), whether or not such restrictions or obligations expressly mention Dental Office Agents. Dental Office shall ensure that all of its Dental Office Agents comply with all such restrictions and obligations set forth in this Agreement, and Dental Office acknowledges and agrees that it is solely responsible for all of its Dental Office Agents' compliance.

ARTICLE II: OBLIGATIONS OF DENTAL OFFICE

2.1 Provision of Services. Dental Office agrees to:

(a) Participate in the Dental Plan(s), as provided by LIBERTY and in accordance with applicable fee schedules, and provide the applicable Covered Services to all Members selecting Dental Office. Dental Office acknowledges and agrees that LIBERTY may delete, add to, or otherwise amend or modify its Dental Plans, and that such deletions, additions, amendments and modifications will be deemed agreed to by Dental Office and shall become part of this Agreement.

(b) Render services in a timely manner consistent with the professional and ethical standards of the American Dental Association ("ADA") and of LIBERTY (including LIBERTY's Dental Director), which services shall be the best possible in light of the technology and medical knowledge which is available at the present time.

(c) Conduct its relationship with LIBERTY and Members in a professional and positive manner, and not make untruthful, inaccurate, misrepresentative or disparaging statements or omissions regarding LIBERTY, its relationship with LIBERTY, LIBERTY Members or LIBERTY's business, nor conduct itself in any fashion that could be detrimental to the business of LIBERTY, as solely determined by LIBERTY.

(d) Post in Dental Office's office(s) a notice to Members regarding the process for resolving complaints with LIBERTY.

2.2 Refusal of Services; Non-discrimination. Dental Office agrees to render all necessary dental services to each Member during Dental Office's regular office hours, subject to prior appointments; provided, however, that Dental Office shall have the right to refuse services to any Member who habitually has broken appointments or has behaved in a grossly discourteous manner toward Dental Office, Dental Office Agents and/or other patients. In order to ensure continuity of care, Dental Office shall immediately report to LIBERTY all such instances where Dental Office refuses services to a Member. Dental Office shall not discriminate in the treatment of Members or in the quality of services delivered to Members on the basis of race, sex, sexual orientation, age, religion, place of residence, health status, membership in a Dental Plan or program, national origin, disability, or source of payment.

2.3 Administrative Duties. To enable LIBERTY to maintain appropriate quality assurance and utilization review programs and to comply with applicable laws and regulations, Dental Office shall:

(a) Provide to LIBERTY an accurate and detailed description of all Covered Services rendered to Members on ADA Claim Forms and shall complete and submit such forms to LIBERTY as Covered Services are performed. Dental Office shall comply with all applicable clean claims requirements, in accordance with applicable law and regulation and as set forth in the most current LIBERTY provider manual or administrative guidelines. Dental Office's failure to submit a Clean Claim forfeits Dental Office's right to payment on that claim unless the failure was the result of a catastrophic event that substantially interfered with the Dental Office's normal business operations.

(b) Meet and maintain all credentialing (including federal, state and/or NCQA guidelines) and other professional qualification requirements of LIBERTY. In addition, Dental Office agrees that it has and will maintain without interruption (and that all of its Dental Office Agents have and will maintain without interruption) all applicable licenses, certifications and qualifications required by applicable federal and state laws and regulations to perform services under this Agreement.

(c) Cooperate with LIBERTY in maintaining dental, financial, administrative and any other records relating to a Member (or relating to any services provided pursuant to this Agreement) and in providing such records to LIBERTY promptly upon LIBERTY's request. When provided to LIBERTY, these records shall maintain the confidential nature they had while in the possession of Dental Office.

(d) Cooperate with LIBERTY, and participate at LIBERTY's direction, in service standards, quality assurance, peer review and audit systems, on-site inspections and grievance procedures, as further set forth by LIBERTY in its provider manual, administrative guidelines, or otherwise. Dental Office shall comply with all final determinations rendered by the peer review process or grievance procedures established by LIBERTY. Dental Office shall also cooperate with LIBERTY by providing copies of state licenses or certificates immediately upon LIBERTY's request.

(e) Provide written notice to LIBERTY immediately upon any changes to the information provided to LIBERTY on the Dental Office's provider application (or the provider application of any of its Dental Office Agents, if applicable). In addition, Dental Office shall provide immediate written notice to LIBERTY of any suspension or revocation of Dental Office's licenses, certifications or qualifications, of any investigation of Dental Office by a governmental agency or division, or any litigation or other legal proceeding involving Dental Office and a Member.

2.4 Confidentiality.

(a) *Member Information.* Dental Office shall safeguard Members' privacy and confidentiality, assure accuracy of Members' health records and maintain records of Members in an accurate and timely manner. Dental Office agrees to comply with all state and federal laws, rules and regulations or applicable program requirements regarding the privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information, including without limitation the Health Insurance Portability and Accountability Act and any rules and regulations promulgated thereunder (collectively, "HIPAA"), as well as the Health Information Technology for Economic and Clinical Health Act and any rules and regulations promulgated thereunder (collectively, "HITECH Act"). Dental Office also agrees to release such information only in accordance with applicable state and federal laws or pursuant to court orders by a court of competent jurisdiction or validly issued subpoenas.

(b) *LIBERTY Information.* Dental Office acknowledges that, by reason of its performance of services under this Agreement, Dental Office may have access to confidential and/or proprietary information of LIBERTY and of other third parties, including, without limitation, information and knowledge pertaining to products, services, benefits, policies, inventions, discoveries, improvements, innovations, designs, ideas, trade secrets, advertising, marketing, finances, distribution and sales methods, sales and profit figures, databases, member, subscriber and provider lists, identifying information regarding members and subscribers, and relationships and agreements between LIBERTY and providers, regulators and others who have business dealings with them (collectively, "Confidential Information"). Dental Office acknowledges that such Confidential Information is a valuable and unique asset of LIBERTY and/or the other third parties to which such Confidential Information belongs, and Dental Office hereby covenants that during the term of this Agreement, Dental Office shall: (i) keep the Confidential Information in strictest confidence and use the Confidential Information for no other purpose than,

and only to the extent necessary, to carry out its obligations under this Agreement; and (ii) not disclose any Confidential Information to any third party without the prior written authorization of LIBERTY. Upon termination or expiration of the Agreement, Dental Office shall return all such Confidential Information (except the Records, as defined below, which it has a duty to maintain) to LIBERTY. Following termination or expiration of the Agreement, Dental Office shall not in any way use or disclose the Confidential Information. The obligation of confidentiality imposed by this Section 2.4(b) ("LIBERTY Information") shall not apply to Confidential Information that is publicly known and generally available to the public through no act or omission of Dental Office or which is required to be disclosed by validly issued subpoena, by order of a court of competent jurisdiction or by applicable law or other legal or governmental process (collectively, "Required Disclosure"); provided, however, that in the case of Required Disclosure, Dental Office shall immediately provide written notice to LIBERTY of such request(s) and shall use reasonable efforts to resist disclosure until an appropriate protective order may be sought by, or a waiver of compliance with the terms of this Agreement has been granted by, LIBERTY. In the absence of a protective order or receipt of a waiver hereunder, if Dental Office is nonetheless, in the written opinion of its counsel, legally required to disclose the Confidential Information, then Dental Office may disclose such information, provided that LIBERTY has been given a reasonable opportunity to review the text of such disclosure before it is made and that disclosure is limited to only the Confidential Information specifically required to be disclosed.

2.5 Inspection, Evaluation, Audit; Document Retention.

(a) *Access to Records.* Dental Office shall permit LIBERTY and all applicable governmental agencies or divisions (and/or the designees of LIBERTY or such governmental agency/division) to inspect, evaluate and audit any physical facilities and equipment, books, contracts, documents, papers, records, including dental records and documentation of the Dental Office that pertain to the Member, any aspect of Covered Services performed, reconciliation of benefits and determination of amounts payable (the "Records"). Dental Office shall cooperate and assist with, and provide the Records to, LIBERTY and any applicable governmental agency/division (and/or their designees) for purposes of the above inspections, evaluations, and /or audits, as requested. Dental Office may not make the access described in this Section 2.5(a) ("Access to Records") contingent upon a confidentiality statement or agreement. The above-described rights to inspect, evaluate and audit will extend through the period during which Dental office is required to maintain the Records as set forth in Section 2.5(b) ("Retention Period") below.

(b) *Retention Period.* Dental Office shall maintain the Records for ten (10) years from the termination or expiration of the Agreement, unless otherwise required by law.

2.6 Hold Harmless. Dental Office agrees that in no event, including but not limited to non-payment by LIBERTY, insolvency of LIBERTY or breach of this Agreement, shall Dental office bill, collect a deposit from, impose surcharges or have any recourse against a Member or a person acting on behalf of a Member for Covered Services provided pursuant to this Agreement. The Agreement does not prohibit Dental Office from collecting Member Cost Sharing, as specifically provided in the applicable plan description provided by LIBERTY and in effect at that time, or fees for non-covered services as long as the Member has been informed in advance that services are not covered and that Member is financially responsible for any non-covered services and as long as Dental Office has complied with any other LIBERTY policies, rules or guidelines governing non-covered services. This provision will survive termination of the Agreement, regardless of the reason for termination, including the insolvency of LIBERTY, and shall supersede any oral or written agreement between Dental Office and Member.

2.7 Insurance. Dental Office shall secure and maintain policies of general and professional liability insurance necessary to insure Dental Office (and Dental Office Agents) against any liabilities or claims for damages arising by reason of injury or death, occasioned directly or indirectly, in connection with the performance or nonperformance of any service by Dental Office or by Dental Office Agents under this Agreement. Dental Office (and each dentist of Dental Office) shall secure and maintain minimum coverage limits for professional liability insurance of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate. Dental Office shall also require that every dental hygienist and all appropriate dental auxiliaries employed by or contracted with Dental Office shall maintain professional liability insurance of similar limits or be named insured on Dental Office's professional liability insurance policy. Dental Office shall deliver to LIBERTY satisfactory evidence of all such insurance coverage during each year of this Agreement or upon LIBERTY's request and shall further notify LIBERTY immediately of any and all substantial changes in or cancellation of said insurance coverage. The failure of Dentist to secure and maintain such professional liability insurance shall constitute a material breach of this Agreement.

2.8 Indemnification. LIBERTY shall not be liable for any act or omission by Dental Office or by any Dental Office Agents in connection with, or arising out of, the performance or nonperformance of any services by Dental Office/Dental Office Agents with

respect to Members ("Dental Office Acts/Omissions"). Dental Office shall indemnify, defend and hold harmless LIBERTY (and LIBERTY's affiliates, subsidiaries, parent corporations, officers, directors, shareholders, managers, members and employees) from and against any and all losses, costs, damages, obligations, liabilities, awards and expenses (including, without limitation: defense costs; reasonable attorney's fees; court costs; exemplary damages, including but not limited to compensatory, consequential and punitive damages; penalties and fines; and interest), which arise out of or are in any way related to: (i) any Dental Office Acts/Omissions; (ii) Dental Office's (or a Dental Office Agent's) breach of this Agreement; or (iii) any representations, warranties, covenants, agreements, obligations, or acknowledgments of Dental Office or a Dental Office Agent as set forth in this Agreement (including but not limited to any provider application form).

2.9 Non-Solicitation of Members. Dental Office agrees that during the term of this Agreement and for the one-year (1-year) period following termination or expiration of this Agreement, Dental Office shall not solicit or otherwise approach then current LIBERTY Members to become members in a prepaid dental plan, preferred provider organization or any other managed dental delivery system (other than LIBERTY) to which Dental Office is a provider or has an ownership interest, nor shall Dental Office in any fashion encourage any Member to terminate from LIBERTY. The foregoing is not intended to limit Dental Office's communications with any Member with respect to the Member's condition or treatment options, the terms of the applicable dental plan as relates to Member's dental needs, the termination of this Agreement to the extent it affects the Member or the coverage of dental services, subject to the terms set forth in Section 6.2 of this Agreement ("Communications").

2.10 Compliance with Laws and Regulations. Dental Office agrees to comply with all applicable federal and state laws, rules and regulations, as may be amended from time to time.

ARTICLE III: QUALITY ASSURANCE

3.1 Compliance with Policies and Procedures. Dental Office agrees to perform services for Members with the same professional and ethical standards of care, skill, and diligence as generally promulgated by the ADA and in accordance with the policies and procedures established by LIBERTY from time to time. Dental Office shall comply with all policies and procedures of LIBERTY, which policies include but are not limited to standards for timeliness of access to care, policies and procedures regarding coverage rules and payment, LIBERTY's accreditation standards, and policies related to LIBERTY's compliance program. Dental Office shall comply with all policies, procedures and guidelines identified in LIBERTY's current provider manual and/or administrative guidelines, which may be amended from time to time by LIBERTY.

3.2 Quality Assurance. LIBERTY shall develop, implement and maintain a Quality Management and Improvement Program ("QMI Program"), policies and procedures and service standards. Dental Office shall be bound by, and shall comply with, the QMI Program and such policies and procedures and service standards as may be set forth in the LIBERTY provider manual or administrative guidelines.

3.3 Radiology Equipment. If Dental Office utilizes radiology or radiographic equipment at its facility in rendering services pursuant to this Agreement, Dental office shall have such equipment regularly checked by local or state health authorities or a radiation physicist to ensure that such equipment is environmentally safe and technologically accurate. Any hazards identified by such inspections or at any time shall be promptly corrected. Dental Office shall maintain equipment maintenance and calibration records and all inspection certificates or reports, all of which records, certificates and reports shall be available for review by LIBERTY upon request.

ARTICLE IV: COMPENSATION

4.1 Fees. In exchange for the provision of Covered Services to Members, Dentist shall be compensated in accordance with the applicable fees set forth in Exhibit A or as set forth in the applicable compensation addendum or fee schedule provided by LIBERTY or mutually agreed upon by the Parties. Dental Office acknowledges and agrees that all such fees will be based on the current, applicable Dental Plan(s). Dental Office agrees to accept such fees and any applicable Cost Sharing as payment in full for the rendered Covered Services.

4.2 Coordination of Benefits/Subrogation Claims. The value of any benefits or services provided under this Agreement may be coordinated with any other type of group insurance plan or coverage under governmental programs pursuant to the requirements of applicable federal or state laws or regulations. Dental Office agrees to cooperate with LIBERTY in connection with its efforts to coordinate benefits or with respect to any subrogation claim LIBERTY may pursue.

ARTICLE V: TERM AND TERMINATION

5.1 Term. This Agreement shall continue in effect for one (1) year from the Effective Date. This Agreement will automatically renew on the same terms and conditions for subsequent twelve-month (12-month) periods unless terminated in accordance with the termination provisions herein.

5.2 Termination.

(a) *By mutual agreement.* This Agreement may be terminated at any time upon the mutual agreement of the parties by a writing executed by an authorized signatory of each Party.

(b) *By either party.* Either Party may terminate this Agreement with or without cause by providing written notice to the other Party at least ninety (90) days prior to the intended effective date of the termination.

(c) *By LIBERTY.* LIBERTY may deactivate Dental Office from further Member selection if LIBERTY determines that it needs to do so to investigate Dentist compliance with Agreement terms, though LIBERTY is not obligated to do so. LIBERTY may also terminate this Agreement as follows:

(1) LIBERTY may terminate this Agreement immediately and without possibility of reinstatement upon cure if LIBERTY determines, in its sole discretion, that one or more Members' health may be impaired by the continuation of this Agreement or if LIBERTY determines that any of the following events have occurred with respect to Dental Office, which determinations shall be made by LIBERTY in good faith: (i) the restriction, suspension or revocation of Dental Office's licenses or certifications, (ii) Dental Office's loss of, or failure to maintain, general and/or professional liability insurance as required under this Agreement, (iii) Dental Office's exclusion from participation in Medicare, Medicaid, or any other third party, state or federal programs, (iv) felony conviction of Dental Office, (v) impairment of Dental Office's ability to provide services, (vi) fraud by Dental Office, or (vii) Dental Office's failure or inability at any time to satisfy LIBERTY's credentialing criteria, as in effect from time to time. LIBERTY also has the right to, in its sole discretion, terminate the Agreement with respect to the participation of only a particular dentist or dentists of Dental Office in the event of any of the foregoing occurrences as they involve such dentist(s).

(2) LIBERTY may also terminate this Agreement upon thirty (30) days' written notice to Dental Office if Dental Office is in breach of any material provision of this Agreement. If such breach is cured within such thirty-day (30-day) notice period, then the Agreement will not be terminated and it shall continue in full force and effect. If such breach is not cured to LIBERTY's satisfaction within such 30-day notice period, LIBERTY may immediately terminate the Agreement.

5.3 Effect of Termination.

(a) *Prior and Continuing Obligations.* Notwithstanding any other provision in this contract, any termination of this Agreement shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination and any continuing obligations after termination as set forth in this Agreement.

(b) *Benefit Continuation; Completion of Work.* In the event of the termination of this Agreement and unless prohibited by applicable law, Dental Office shall complete work started prior to the effective date of termination as follows: (i) if an impression has been taken, Dental Office will complete the partial or denture; (ii) if work has been started on a tooth, Dental Office shall complete work on each such tooth; (iii) if a Member is undergoing orthodontia treatment at the time of termination, Dental Office will complete this work at the agreed-upon discount in the schedule of benefits; and (iv) if, at the time of notice of termination, Dental Office is treating a Member with Special Circumstances, then for Continuity of Care, LIBERTY shall reimburse Dental Office at no less than the contract rate for that Member's dental care in exchange for continued treatment by Dental office, unless Dental Office has been terminated due to a lack of dental competence or professional behavior. LIBERTY shall reimburse the terminated Dental Office for ongoing treatment of Members with Special Circumstances for up to ninety (90) days after the effective date of termination, or for up to nine (9) months in the case of a Member who has been diagnosed with a terminal illness at the time of termination. The treating dentist of Dental Office is responsible for identifying a Member with Special Circumstances. Dental Office must then request that the Member be permitted to continue treatment under Dental Office's care and Dental Office must agree not to seek payment from the Member of any amount for which the Member would not be responsible if Dental Office continued to be included

in LIBERTY's network. Dental Office is responsible for submitting disputes regarding the necessity of continued treatment to the LIBERTY advisory review panel.

(c) *Records.* In the event of termination of this Agreement, Dental Office agrees to, at no cost to Member or LIBERTY, forward to the Member's newly-assigned dentist, at the request of the Member or newly-assigned dentist, copies of all patient records and copies of x-rays of Member, within thirty (30) days after such request. Dental Office further agrees to return all LIBERTY materials to LIBERTY, including all manuals or reference guides.

(d) *Notification to Members.* LIBERTY will notify members regarding provider termination prior to the effective date. Dentist agrees to charge the Member no more for his services than would have been payable by the Member had this Agreement not terminated.

ARTICLE VI: GENERAL PROVISIONS

6.1 Financial Records. Dental Office shall cooperate with LIBERTY in keeping financial and statistical records which may be necessary for LIBERTY's proper administration or as required by state or federal laws and regulations. Such records shall be retained for a period of five (5) years following termination or expiration of this Agreement.

6.2 Communications. Any written mass communication relating to LIBERTY or its Dental Plans (whether or not LIBERTY is specifically named) directed to Members by Dental Office must be reviewed and approved by LIBERTY prior to mailing. If Dental Office fails to submit such communications to LIBERTY for prior approval, LIBERTY may terminate this Agreement immediately.

6.3 Dental Communications. LIBERTY shall not prohibit, attempt to prohibit, or discourage Dental Office from discussing with or communicating to a current, prospective, or former Member, or a party designated by Member with respect to: (i) information or opinions regarding Member's dental care, including the Member's medical or dental condition or treatment options, (ii) information regarding the provisions, terms, requirements, or services of the dental plan as they relate to the dental needs of the Member, and (iii) the fact that Dental Office's contract with LIBERTY has terminated or that Dental Office will no longer be providing dental services under LIBERTY's Dental Plans.

6.4 Provider Manual. LIBERTY's provider manual and/or administrative guidelines, and any updates thereto, will be provided by paper, CD-ROM, or via LIBERTY's website. LIBERTY reserves the right to amend, modify, supplement or remove terms or provisions of its provider manual/administrative guidelines at any time and from time to time.

6.5 Dispute Resolution Process. Any dispute, claim or controversy between the Parties arising out of or relating to this Agreement shall be resolved by mediation or in the event such dispute, claim or controversy cannot be resolved by mediation, by binding arbitration pursuant to the rules and procedures of the American Arbitration Association. This section shall not apply to disputes arising from malpractice claims or other claims of Members or other third parties, nor shall this section preclude the Parties from pursuing equitable relief in a court of competent jurisdiction. Dental Office further agrees to abide by the terms of any arbitration, mediation or grievance procedure provisions set forth in Plan Description. This section shall also not apply to disputes arising from utilization management decisions of LIBERTY, it being understood and acknowledged by the Parties that Dental Office's rights in connection with such decisions are specified in the UMI program.

6.6 Miscellaneous.

a) *Applicable Law.* This Agreement and the rights and obligations of the parties hereto shall be interpreted, construed and enforced in accordance with the laws of the state in which Dental Office is contracted by LIBERTY to provide Covered Services under this Agreement.

b) *Waiver.* No failure or delay by LIBERTY or any representative of LIBERTY in exercising any right, power, or privilege hereunder shall operate as a waiver thereof, nor will any single or partial exercise thereof preclude any other or further exercise thereof of the exercise of any other right, power, or privilege hereunder. In addition, the waiver by LIBERTY of a breach of any provision of this Agreement by Dental Office shall not operate as or be construed as a waiver of any subsequent breach by Dental Office.

c) *Entire Agreement.* This Agreement (including any applicable provider application, any applicable provider manual and/or administrative guidelines, and all applicable attachments, exhibits, addenda and fee schedules) is the final expression of,

and contains the entire agreement between, the Parties with respect to the subject matter hereof and supersedes all prior communications or understandings with respect thereto.

d) *Severability.* If any provision, term, covenant or condition contained in this Agreement is held by any court of competent jurisdiction to be invalid, unenforceable or void, such invalidity or unenforceability shall not affect the validity and enforceability of the remainder of the Agreement and all other provisions, terms, covenants and conditions contained in the Agreement shall remain in full force and effect. In addition, any invalid, unenforceable, or void provision, term, covenant or condition of this Agreement shall be replaced with a valid and enforceable one that will achieve, to the extent possible, the economic, business, and other purposes of the invalid, unenforceable, or void provision, term, covenant or condition.

e) *Amendments.* The Parties acknowledge and agree that this Agreement may be required to be modified from time to time, without Dental Office's consent, in order to comply with applicable federal and state laws or regulations. In that regard, the Parties agree that any changes in applicable law that do not require this Agreement to be modified by a written amendment shall be automatically incorporated herein and that, where any changes in applicable law require this Agreement to include or not include certain language or provisions, such modification to language or provisions shall occur automatically without the need for the Parties to execute any amendment to this Agreement. In addition, LIBERTY may remove, amend, modify or supplement any term or provision of this Agreement (including the addition of addenda and/or exhibits) upon written notice to Dental Office; if Dental Office fails to object to such modification in writing within ten (10) days of such notification, Dental Office will be deemed to have consented to such modification. Except for the foregoing, this Agreement may not otherwise be amended, modified, changed, or supplemented in any way except by written instrument signed by an authorized signatory of each Party.

f) *Dental Office Representations.* Dental Office makes the following material representations and warranties to LIBERTY in order to induce LIBERTY to enter into this Agreement, and Dental Office acknowledges that LIBERTY has reasonably relied upon each of these representations and warranties and that but for each and every one of these representations and warranties, LIBERTY would not enter into this Agreement.

i. *Qualifications.* Dental Office represents and warrants that it has all applicable qualifications, certifications and licenses needed to perform the Covered Services.

ii. *No Conflicting Commitments.* Dental Office represents and warrants that it is free to enter into this Agreement and is not bound by any employment agreement, services agreement, nondisclosure or confidentiality agreement, non-competition agreement or any other agreement, document or obligation that may infringe upon or limit Dental Office's ability to perform, or may in any manner prevent Dental Office from performing, any of its obligations under this Agreement. Dental Office represents and warrants that there are no other agreements, relationships or commitments to any other person or entity that conflict with Dental Office's obligations to LIBERTY under this Agreement.

iii. *Signatory Authority.* By signing below, the signatory of Dental Office represents and warrants that he or she has the authority to bind Dental Office to this Agreement.

g) *Agreement Assignment.* This Agreement may be freely assigned by LIBERTY without the consent of Dental Office. This Agreement may not be assigned by Dental Office without the prior written consent of LIBERTY. Notwithstanding the foregoing, this Agreement shall be binding upon, inure to the benefit of and be enforceable by the successors, assigns, heirs, executors and administrators of the Parties.

h) *Survival.* To the extent Dental Office performs any continuing treatment required by this Agreement, all terms of this Agreement shall remain in full force and effect until such continuing treatment has concluded. In addition, all of the Parties' continuing rights and obligations under this Agreement, including but not necessarily limited to the following provisions, survive termination of this Agreement: Sections 1.1, 1.2, 2.1(c), 2.3(c)-(d), 2.4, 2.5, 2.6, 2.8, 2.9, 5.3, 6.1, 6.2, 6.5, 6.6.

i) *Headings.* The headings of the sections/paragraphs of this Agreement are for convenience only and may not in any way affect the meaning or interpretation of this Agreement.

j) *Counterparts.* This Agreement may be executed in several counterparts (including by facsimile or by an electronic scan delivered by electronic mail) that together shall constitute a single agreement.

k) *Notices.* Any notices required to be given hereunder shall be in writing and shall be: (i) delivered in person to any signatory hereof, (ii) mailed by certified mail, postage prepaid, return receipt requested, or (iii) mailed by a commercial overnight courier that provides receipt of delivery. Notice shall be deemed effective upon the date of delivery. Either Party may at any time change its address by mailing a notice as required above. Until notice of a change of address is given, all such notices shall be given or addressed as follows:

To LIBERTY:
LIBERTY Dental Plan Corporation
Attn: Professional Relations
340 Commerce, Suite 100
Irvine, CA 92602

To Dental Office:
Address specified on signature page

IN WITNESS WHEREOF, this Agreement has been executed as of the Effective Date:

("DENTAL OFFICE"):

Authorized Signature

Print Name of Signatory

Title

Date

Dental Office Name

Dental Office Address

City, State ZIP

Primary Dentist License #

SS# and/or Tax ID#

Individual National Provider Identifier (NPI)

Organizational National Provider Identifier (NPI)

LIBERTY Dental Plan Corporation ("LIBERTY"):

Signature

Print Name of Signatory

Title

Effective Date

ILLINOIS MEDICAID PROGRAM ADDENDUM

THIS ILLINOIS MEDICAID PROGRAM ADDENDUM (the "Addendum") is intended to supplement the Provider Agreement (the "Agreement") entered into by and between LIBERTY Dental Plan Corporation (collectively with any affiliates, subsidiaries and parent corporations performing services for Payor with respect to the Members, "LIBERTY") and the legal entity or individual qualified and licensed to practice dentistry in the state of Illinois as defined in the Agreement and as specified on the signature page of this Addendum ("Dental Office") (together, the "Parties"). This Addendum is intended to set forth the requirements governing the relationship between the Parties, Payor, and the Illinois Department of Healthcare and Family Services (the "Department" or "DHS") with respect to the provision of Medicaid services to Members. Except as expressly modified by this Addendum, the Agreement remains in full force and effect and all capitalized terms in this Addendum (which are not otherwise defined) shall have the meaning ascribed to them in the Agreement. All rights granted to and obligations imposed upon Dental Office that are set forth in this Addendum shall apply with equal force to any dentist of Dental Office who is contracted with LIBERTY.

1. Definitions.

   a. "**Abuse**" means a manner of operation that results in excessive or unreasonable costs to the Federal and/or State health care programs.

   b. "**Action**" means a (i) denial or limitation of authorization of a requested service; (ii) reduction, suspension, or termination of a previously authorized service; (iii) denial of payment for a service; (iv) failure to provide services in a timely manner; (v) failure to respond to an appeal in a timely manner; and (vi) solely with respect to a managed care organization that is the only contractor serving a rural area, the denial of a Member's request to obtain services outside of the Contracting Area.

   c. "**Appeal**" means a request for review of a decision made by Payor with respect to an Action.

   d. "**Authorized Person**" means a representative of the Office of Inspector General for the Department, the Illinois Medicaid Fraud Control Unit, DHHS, a representative of other State and Federal agencies with monitoring authority related to the HFS Medical Program, or a representative of any external quality review organization under contract with the Department.

   e. "**Department**" means the Illinois Department of Healthcare and Family Services.

   f. "**Emergency Condition**" means a condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions or (iii) serious dysfunction of any bodily organ or part.

   g. "**Emergency Services**" means those inpatient and outpatient health care services that are Covered Services, including transportation, needed to evaluate or stabilize an Emergency Condition, which are furnished by a Dental Office qualified to furnish emergency services.

   h. "**Fraud**" means knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

   i. "**Grievance**" means a Member's expression of dissatisfaction, including complaints, about any matter other than a matter that is properly the subject of an Appeal.

   j. "**HFS Medical Program**" means the Illinois Medical Assistance Program administered under Article V of the Illinois Public Aid Code (305 ILCS 5/5-1 et. seq.) or its successor program, and Titles XIX (42 USC 1396 et. seq.)

and XXI (42 USC 1397aa et. seq.) of the Social Security Act and Section 12-4.35 of the Illinois Public Aid Code (305 ILCS 5/12-435); the State Children's Health Insurance Program administered under 215 ILCS 106 and Title XXI of the Social Security Act (42 USC 1397aa et. seq.).

k. "**Illinois Contract**" means a contract between the Department and Payor for Payor to provide or arrange for the provision of health care items and services to enrollees in the HFS Medical Program, as amended from time to time. A copy of the Illinois model contract for Medicaid and CHIP as of the Effective Date is available at http://www.hfs.illinois.gov/assets/mco.pdf.

l. "**Ineligible Person**" means a Person which: (i) under either Section 1128 or Section 1128A of the Social Security Act, is or has been terminated, barred, suspended or otherwise excluded from participation or has voluntarily withdrawn from participating in, as a result of a settlement agreement, any program under Federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act; (ii) has not been reinstated in the HFS Medical Program or Federal health care programs after a period of exclusion, suspension, debarment, or ineligibility; or (iii) has been convicted of a criminal offense related to the provision of health care items or services in the last ten years.

m. "**Dental Necessary**" or "**Dental Necessity**" means a service, supply or medicine is appropriate and meets the standards of good dental practice in the dental community for the diagnosis or treatment of a covered illness or injury, the prevention of future disease, to assist the Member's ability to attain, maintain or regain functional capacity, or to achieve age-appropriate growth, as determined by the provider in accordance with Payor's or LIBERTY's guidelines, policies and/or procedures.

n. "**Member**" means an individual enrolled in a Benefit Plan issued by Payor pursuant to an Illinois Contract (except when referring to a "Member of Congress").

o. "**Person**" means any individual, corporation, proprietorship, firm, partnership, limited liability company, limited partnership, trust, association, governmental authority or other entity, whether acting in an individual, fiduciary or other capacity.

2. All provisions of the Agreement and the Addendum are cumulative. All provisions shall be given effect when possible. If there is inconsistent or contrary language between the Addendum and any other part of the Agreement, the provisions of the Addendum shall prevail with respect to the Program described in this Addendum except to the extent a provision of the Agreement exceeds the minimum requirements of the Addendum.

3. Emergency Services. Dental Office shall not be required to seek prior authorization for Emergency Services. Once a Member who receives Emergency Services is stable, Dental Office shall seek prior authorization for services for the Member in accordance with the Provider Manual.

4. As required by section 6032 of the Deficit Reduction Act of 2005, if Dental Office makes or receives annual Medicaid payments of Five Million Dollars or more it will (a) establish and maintain written policies for all of its employees and its contractors and agents that provide information about the False Claims Act, 31 USC §§ 3729-3733, other administrative remedies, State Laws pertaining to civil and criminal penalties for false claims or statements, and whistleblower protection under such Laws, (b) include as part of its written policies detailed provisions outlining the entity's policies and procedures for detecting and preventing fraud, waste and abuse, and (c) include in any employee handbook a discussion of the relevant laws and administrative remedies, a discussion of whistleblower protections afforded to employees, and the entity's policies and procedures for detecting fraud. Additional guidance may be found at http://www.cms.hhs.gov/smdl/downloads/SMD121306.pdf.

5. In no event, including but not limited to nonpayment by LIBERTY of amounts due Dental Office under the Agreement, insolvency of LIBERTY or any breach of the Agreement by LIBERTY, shall Dental Office or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Member, persons acting on the Member's behalf (other than LIBERTY), the employer or group

contract holder for services provided pursuant to the Agreement; except for the payment of applicable co-payments or deductibles for services covered by the organization or fees for services not covered by Payor. The requirements of this clause shall survive any termination of this Addendum and the Agreement for services rendered prior to such termination, regardless of the cause of such termination. The Members, the persons acting on the Member's behalf (other than LIBERTY), and the employer or group contract holder shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between Dental Office and the Member, persons acting on the Member's behalf (other than LIBERTY) and the employer or group contract holder. [50 ILAC § 5421.50(e); also, as to hospitals 215 ILCS 125/2-8(a)]

6. Dental Office shall provide, arrange for, or participate in the quality assurance programs mandated by the Illinois Health Maintenance Organization Act, unless the Illinois Department of Public Health certifies that such programs will be fully implemented without any participation or action from Dental Office. [215 ILCS 125/2-8(b)]

7. Dental Office shall ensure that it and its employed or subcontracted providers shall provide all of the following, where applicable, to Members upon request: (a) information related to the provider's educational background, experience, training, specialty, and board certification, if applicable; (b) the names of licensed facilities on the provider panel where the provider presently has privileges for the treatment, illness, or procedure that is the subject of the request; or (c) information regarding the provider's participation in continuing education programs and compliance with any licensure, certification, or registration requirements, if applicable. [215 ILCS 134/15(c)]

8. As used in this section, "**Division**" means the Illinois Department of Financial and Professional Regulation-Division of Insurance, and "**Director**" means the Director of the Division.

    a. Notwithstanding anything to the contrary in the Agreement, Dental Office shall provide at least sixty (60) days' notice of termination with cause and at least ninety (90) days' notice of termination without cause. [50 ILAC § 5421.50(a)(5)]

    b. Dental Office has professional liability insurance as required by LIBERTY and such insurance coverage is effective as of the Effective Date of the Agreement. Furthermore, Dental Office shall give at least fifteen (15) days' advance notice to LIBERTY of cancellation of such insurance. [50 ILAC § 5421.50(a)(7)]

    c. Dental Office acknowledges that the Director must disapprove any provider agreement for the reasons listed at 50 ILAC § 5421.50(b). If the Director disapproves the Agreement, the agreement shall terminate at the time of such disapproval. [50 ILAC § 5421.50(b)]

9. <u>Illinois Contract Requirements</u>.

    a. Dental Office shall participate in LIBERTY's health education program. [§ 5.12]

    b. Dental Office agrees that all subcontracts must be in writing, and approved by LIBERTY. Dental Office and any approved subcontracts are subject to the following conditions:

        i. Dental Office shall be bound by the terms and conditions of the Illinois Contract that are appropriate to the service or activity delegated under the Agreement or subcontract, as the case may be. Such requirements include the record keeping and audit provisions of the Illinois Contract, such that the Department or Authorized Persons shall have the same rights to audit and inspect Dental Office and its subcontractors as they have to audit and inspect LIBERTY. [§ 5.21(a)(1)]

        ii. Payor shall remain responsible for the performance of any of its responsibilities delegated to Dental Office and its subcontractors. [§ 5.21(a)(1)]

iii. Dental Office acknowledges that no provider agreement or subcontract, including the Agreement, can terminate the legal responsibilities of Payor to the Department to assure that all activities under the Illinois Contract will be carried out. [§ 5.21(a)(1)]

iv. Dental Office warrants and represents that it and the other Providers are enrolled as providers in the HFS Medical Program. Dental Office warrants and represents that neither it nor any of the other Providers is an Ineligible Person or a Person who has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement. [§ 5.21(a)(1)]

v. Dental Office (A) acknowledges that LIBERTY must furnish all Participating Providers with information about LIBERTY's Grievance and Appeal procedures at the time the Dental Office enters into an agreement with LIBERTY and within 15 days following any substantive change to such procedures, and (B) agrees to cooperate with LIBERTY with respect to such requirement. [§ 5.21(a)(1)]

c. Dental Office warrants and represents the following:

i. The Agreement and Addendum is binding. [§ 5.21(b)(1)]

ii. LIBERTY may promptly terminate the Agreement and Addendum, or impose other sanctions, if the performance of Dental Office is inadequate. [§ 5.21(b)(2)]

iii. LIBERTY shall be entitled to promptly terminate the Agreement if Dental Office (or any employee or contractor used by Dental Office in carrying out the Agreement) is terminated, barred, suspended, or has voluntarily withdrawn as a result of a settlement agreement, under either Section 1128 or Section 1128A of the Social Security Act, from participating in any program under Federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act or are otherwise excluded from participation in the HFS Medical Program. [§ 5.21(b)(3)]

iv. LIBERTY shall be entitled to monitor the performance of Dental Office on an ongoing basis, subject Dental Office to formal review on a triennial basis, and, to the extent deficiencies or areas for improvement are identified during an informal or formal review, require that Dental Office take appropriate corrective action. [§ 5.21(b)(5)]

d. Dental Office (i) acknowledges Payor is obligated to provide copies of any model provider agreement or subcontract or any actual provider agreement or subcontract to the Department upon request, and (ii) agrees to provide LIBERTY with copies of documents and to otherwise cooperate with LIBERTY as necessary for Payor to fulfill its obligations under this requirement. Dental Office also acknowledges the Department reserves the right to require Payor and LIBERTY to amend any subcontract, including the Agreement, upon request as necessary to conform to Payor's duties and obligations under Illinois Contracts, and agrees to cooperate with LIBERTY with respect to any such requirement. [§ 5.21(c)]

e. Dental Office (i) acknowledges that prior to entering into the Agreement and Addendum or other subcontract, Payor is required to submit a disclosure statement to the Department specifying any subcontract and providers or subcontractors in which any of the following have a five percent or more financial interest: (A) any Person also having a five percent or more financial interest in Payor or its affiliates as defined by 42 CFR § 455.101; (B) any director, officer, trustee, partner or employee of Payor or its affiliates; or (C) any member of the immediate family of any Person designated in (A) or (B) above; and (ii) agrees to provide LIBERTY with information and to otherwise cooperate with LIBERTY as necessary for Payor to fulfill its obligations under this requirement. [§ 5.21(d)]

f. Dental Office agrees not to seek or obtain funding through fees or charges to any Member receiving Covered Services pursuant to an Illinois Contract, except as permitted or required by the Department in 89 Ill. Adm. Code 125 and/or the Department's fee-for-service copayment policy then in effect. Dental Office acknowledges that

the provisions of the Illinois Contract state that imposing charges in excess of those permitted under the Illinois Contract is a violation of § 1128B(d) of the Social Security Act and is subject to criminal penalties. [§ 5.24]

g. Dental Office shall report any suspected Fraud, Abuse or criminal acts in the HFS Medical Program by individuals receiving benefits under the HFS Medical Program, which report may be made anonymously through LIBERTY's fraud hotline at (888) 704-9833. Dental Office acknowledges that Payor or LIBERTY may conduct investigations of suspected Fraud or Abuse of Dental Office, and its personnel. Dental Office shall cooperate with such investigations. Dental Office shall cooperate with any investigations of suspected Fraud or Abuse by the Office of Inspector General for the Department. [§ 5.25]

h. Payor nor LIBERTY shall not prohibit or otherwise restrict a Dental Office from advising a Member about the health status of the Member or dental care or treatment for the Member's condition or disease regardless of whether benefits for such care or treatment are provided under the Illinois Contract, if the Dental Office is acting within the lawful scope of practice, and shall not retaliate against a Dental Office for so advising a Member. [§ 5.28]

i. Upon termination of the Illinois Contract, Dental Office shall cooperate with Payor and LIBERTY as to the performance of requirements following termination of the agreement, including cooperation as to completion of customer satisfaction surveys, cooperation with dental records review, all reports for periods of operation, including encounter data, and retention of records. Dental Office warrants that if the Illinois Contract is terminated, Dental Office shall promptly supply all information in its possession or that may be reasonably obtained, which is necessary for the orderly transition of Members and completion of all responsibilities under the Illinois Contract. [§ 8.2]

j. Dental Office shall maintain all business, professional and other records in accordance with 45 CFR Part 74, 45 CFR Part 160 and 45 CFR Part 164 subparts A and E, the specific terms and conditions of the Illinois Contract, and pursuant to generally accepted accounting and dental practice. Dental Office shall maintain, for a minimum of six years after completion of the Illinois Contract and after final payment is made under the Illinois Contract, adequate books, records, and supporting documents to verify the amounts, recipients, and uses of all disbursements of funds passing in conjunction with the Illinois Contract. If an audit, litigation or other action involving the records is started before the end of the six year period, the records must be retained until all issues arising out of the action are resolved.

   i. Dental Office shall make all books, records, and supporting documents related to the Illinois Contract available, at no charge, in Illinois, for review and audit by the Department, DHHS, the Auditor General or other Authorized Persons. Dental Office shall cooperate fully with any such review or audit and to provide full access in Illinois to all relevant materials.

   ii. Dental Office acknowledges and agrees that the Department, the Auditor General or other Authorized Persons may also evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services performed under the Illinois Contract.

   iii. Dental Office shall cooperate with quality assurance reviews performed by the Department to determine whether LIBERTY is providing quality and accessible health care to Members under the Illinois Contract. [§ 9.1]

k. Dental Office shall abide by all Federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Illinois Human Rights Act, and Executive Orders 11246 and 11375. Dental Office shall cooperate with LIBERTY with respect to Payor's obligation under the Illinois Contract

to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under the Illinois Contract. [§ 9.2]

l. Lobbying: Dental Office certifies to the best of its knowledge and belief that:

No federal appropriated funds have been paid or will be paid by or on behalf of Dental Office, to any Person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal loan or grant, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

If any funds other than Federally appropriated funds have been paid or will be paid to any Person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, Contracted Provider shall complete and submit a Federal Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. Such Disclosure Form may be obtained by request from the Illinois Department of Healthcare and Family Services, Bureau of Fiscal Operations.

m. Dental Office acknowledges it is prohibited from giving gifts to employees of the Department, and is prohibited from giving gifts to, or accepting gifts from, any Person who has a contemporaneous contract with the Department involving duties or obligations related to the Illinois Contract. [§ 9.42]

n. Dental Office warrants and certifies that it has and will comply with Executive Order No. 1 (2007). The Order generally prohibits LIBERTY and its subcontractors from hiring the then-serving Governor's family members to lobby procurement activities of the State, or any other unit of government in Illinois including local governments if that procurement may result in a contract valued at over $25,000. This prohibition also applies to hiring for that same purpose any former State employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity. [§ 9.66]

o. Dental Office agrees in accordance with Illinois Public Act 95-0307, all information technology, including electronic information, software systems and equipment, developed or provided under the Illinois Contract must comply with the applicable requirements of the Illinois Information Technology Accessibility Act Standards. More information about the Illinois Information Technology Accessibility Act is available at http://www.dhs.state.il.us/iitaa. [§ 9.69]

("DENTAL OFFICE")	**LIBERTY Dental Plan Corporation ("LIBERTY"):**
Authorized Signature	Signature
Print Name	Print Name
Title	Title
Date	Effective Date
Individual Medicaid Number	
Group Medicaid Number (if applicable)	

Exhibit A-2

LIBERTY Dental Plan Corporation Provider Agreement
Government Programs
IL-Child Medicaid FFS Addendum

This IL-Child Medicaid FFS Addendum (the "Addendum") to the LIBERTY Dental Plan Corporation Provider Agreement (the "Agreement") between LIBERTY Dental Plan Corporation ("LIBERTY," as defined in the Agreement) and the legal entity or individual specified in the Agreement and on the signature page of this Addendum and which/who is qualified and licensed to practice dentistry in the state for which it/he/she is contracted by LIBERTY to perform services ("Dental Office," as further defined in the Agreement) is meant to supplement the Agreement. Except as expressly modified by this Addendum, the Agreement remains in full force and effect and all capitalized terms in this Addendum (which are not otherwise defined) shall have the meaning ascribed to them in the Agreement. LIBERTY and Dentist agree as follows:

1. *Reimbursement/Compensation.* LIBERTY shall pay Dental Office certain Fees for covered Services (whose procedural codes are expressly listed below) that are rendered to eligible Members by qualified dentists in the contracted facilities in accordance with the terms of the Agreement. For purposes of this Addendum, "Fee" is defined as the amount of the applicable fees listed below minus the amount of any applicable Member copayment.

Code	Description of Services	Fee
	DIAGNOSTIC	
D0120	Periodic Oral Evaluation, Established Patient	$28.00
D0140	Limited Oral Evaluation, Problem Focused	$16.20
D0150	Comprehensive Oral Evaluation	$21.05
D0210	Full Mouth X-Ray	$30.10
D0220	Periapical, First Image	$5.60
D0230	Periapical, Each Additional Image	$3.80
D0270	Bitewings, Single Image	$5.60
D0272	Bitewings, Two Images	$9.40
D0274	Bitewings, Four Images	$16.90
D0277	Vertical bitewings, 7 to 8 radiographic images	$16.90
D0330	Panoramic radiographic image	$22.60
	PREVENTATIVE	
D1110	Prophylaxis, Adult	$25.40
D1120	Prophylaxis, Child	$41.00
D1206	Topical application of fluoride varnish	$26.00
D1208	Topical application of fluoride	$26.00
D1351	Sealant, per tooth	$36.00
D1510	Space maintainer, fixed, unilateral	$70.60
D1515	Space maintainer, fixed, bilateral	$103.50
D1520	Space maintainer, removable, unilateral	$70.60
D1525	Space maintainer, removable, bilateral	$74.70
D1550	Recementation of space maintainer	$10.70
	RESTORATIVE	
D2140	Amalgam, 1 Surface, Primary or Permanent	$30.85
D2150	Amalgam, 2 Surfaces, Primary or Permanent	$48.15
D2160	Amalgam, 3 Surfaces, Primary or Permanent	$58.05
D2161	Amalgam, 4 or More Surfaces, Primary or Permanent	$58.05
D2330	Resin-Based Composite, 1 Surface, Anterior	$34.60
D2331	Resin-Based Composite, 2 Surfaces, Anterior	$51.90
D2332	Resin-Based Composite, 3 Surfaces, Anterior	$61.80
D2335	Resin-Based Composite, 4+ Surfaces or Involving Incisal Angle (Anterior)	$61.80
D2391	Resin-Based Composite, 1 Surface, Posterior	$30.85
D2392	Resin-Based Composite, 2 Surfaces, Posterior	$48.15
D2393	Resin-Based Composite, 3 Surfaces, Posterior	$58.05

Code	Description of Services	Fee
D2394	Resin-Based Composite, 4+ Surfaces, Posterior	$58.05
D2740	Crown, porcelain/ceramic	$235.20
D2750	Crown, porcelain fused to high noble metal	$235.20
D2751	Crown, porcelain fused to predominantly base metal	$235.20
D2752	Crown, porcelain fused to noble metal	$235.20
D2790	Crown, full cast high noble metal	$145.85
D2791	Crown, full cast predominantly base metal	$145.85
D2792	Crown, full cast noble metal	$145.85
D2910	Recement inlay, onlay, partial coverage restoration	$11.30
D2915	Recement cast or prefabricated post & core	$23.50
D2920	Recement crown	$23.50
D2930	Prefabricated stainless steel crown, primary tooth	$73.40
D2931	Prefabricated stainless steel crown, permanent tooth	$73.40
D2932	Prefabricated resin crown	$56.45
D2933	Prefabricated stainless steel crown, resin window	$56.45
D2934	Prefabricated esthetic coated SS crown, primary	$73.40
D2940	Protective restoration (temporary)	$11.30
D2950	Core build-up, including any pins	$58.05
D2951	Pin retention, per tooth, in addition to restoration	$9.40
D2954	Prefabricated post & core in addition to crown	$32.90
	ENDODONTICS	
D3220	Therapeutic pulpotomy (excluding final restoration)	$52.70
D3222	Partial pulpotomy for apexogenesis	$60.35
D3230	Pulpal therapy (resorbable filling), anterior primary	$52.70
D3310	Root canal - anterior (excluding final restoration)	$136.40
D3320	Bicuspid (excluding final restoration)	$155.25
D3330	Molar (excluding final restoration)	$202.30
D3351	Apexification/recalcification/pulp reg. – initial visit	$28.20
D3352	Apexification/recalcification/pulp reg. – interim med.	$14.10
D3353	Apexification/recalcification – final visit	$14.10
D3410	Apicoectomy/periradicular surgery – anterior	$112.90
	PERIODONTICS	
D4210	Gingivectomy or Gingivoplasty, 4+ teeth per quad	$131.70
D4211	Gingivectomy or Gingivoplasty, 1-3 teeth per quad	$65.85
D4240	Gingival flap procedure, 4+ teeth per quadrant	$229.60
D4241	Gingival flap procedure, 1-3 teeth per quadrant	$114.80
D4260	Osseous surgery, 4+ teeth per quadrant	$277.60
D4261	Osseous surgery, 1-3 teeth per quadrant	$138.80
D4263	Bone replacement graft, 1st site in quadrant	$141.15
D4264	Bone replacement graft, each add 'l site, quadrant	$70.60
D4270	Pedicle soft tissue graft procedure	$141.15
D4273	Subepithelial connective tissue graft, per tooth	$141.15
D4274	Distal/proximal wedge procedure	$70.60
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous position in graft	$141.15
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	$141.15
D4320	Provisional splinting - intracoronal	$188.20
D4321	Provisional splinting - extracoronal	$56.50
D4341	Periodontal scaling & root planing, 4+ teeth per quad	$122.00
D4342	Periodontal scaling & root planing, 1-3 teeth per quad	$77.00
D4355	Full mouth debridement	$62.00

Code	Description of Services	Fee
D4910	Periodontal maintenance	$67.00
	PROSTHODONTICS, REMOVED	
D5110	Complete Denture, Maxillary	$376.35
D5120	Complete Denture, Mandibular	$376.35
D5130	Immediate Denture, Maxillary	$376.35
D5140	Immediate Denture, Mandibular	$376.35
D5211	Maxillary Partial Denture, Resin Base	$357.55
D5212	Mandibular Partial Denture, Resin Base	$357.55
D5213	Maxillary partial denture, cast metal/resin base	$366.95
D5214	Mandibular partial denture, cast metal/resin base	$366.95
D5510	Repair Broken Complete Denture Base	$61.15
D5520	Replace Missing Or Broken Teeth, Complete Denture	$38.10
D5610	Repair Resin Denture Base, Partial Denture	$51.75
D5620	Repair cast framework	$79.05
D5630	Repair or replace broken clasp	$71.50
D5640	Replace Broken Teeth, Partial Denture	$37.65
D5650	Add Tooth To Existing Partial Denture	$42.35
D5730	Reline Complete Maxillary Denture (Chairside)	$70.60
D5731	Reline Complete Mandibular Denture (Chairside)	$70.60
D5740	Reline Maxillary Partial Denture (Chairside)	$70.60
D5741	Reline Mandibular Partial Denture (Chairside)	$70.60
D5750	Reline Complete Maxillary Denture (Laboratory)	$117.60
D5751	Reline Complete Mandibular Denture (Laboratory)	$117.60
D5760	Reline Maxillary Partial Denture (Laboratory)	$117.60
D5761	Reline Mandibular Partial Denture (Laboratory)	$117.60
D5911	Facial moulage (sectional)	$361.25
D5912	Facial moulage (complete)	$453.90
D5913	Nasal prosthesis	$1,020.00
D5914	Auricular prosthesis	$1,020.00
D5915	Orbital prosthesis	$510.00
D5916	Ocular prosthesis	$1,020.00
D5919	Facial prosthesis	$1,020.00
D5922	Nasal septal prosthesis	$510.00
D5923	Ocular prosthesis, interim	$510.00
D5924	Cranial prosthesis	$1,190.00
D5925	Facial augmentation implant prosthesis	$255.00
D5926	Cranial prosthesis	$255.00
D5927	Auricular prosthesis, replacement	$255.00
D5928	Orbital prosthesis, replacement	$255.00
D5929	Facial prosthesis, replacement	$255.00
D5931	Obturator prosthesis, surgical	$850.00
D5932	Obturator prosthesis, definitive	$1,275.00
D5933	Obturator prosthesis, modification	$191.25
D5934	Mandibular resection prosthesis with guide flange	$1,445.00
D5935	Mandibular resection prosthesis without guide flange	$1,190.00
D5936	Obturator prosthesis, interim	$765.00
D5937	Trismus appliance (not for TMD treatment)	$106.25
D5951	Feeding aid	$170.00
D5952	Speech aid prosthesis, pediatric	$680.00
D5953	Speech aid prosthesis, adult	$1,232.50
D5954	Palatal augmentation prosthesis	$170.00
D5955	Palatal lift prosthesis, definitive	$1,190.00

Code	Description of Services	Fee
D5958	Palatal lift prosthesis, interim	$680.00
D5959	Palatal lift prosthesis, modification	$187.00
D5960	Speech aid prosthesis, modification	$187.00
D5982	Surgical stent	$106.25
D5983	Radiation carrier	$68.00
D5984	Radiation shield	$170.00
D5985	Radiation cone locator	$170.00
D5986	Fluoride gel carrier	$68.00
D5987	Commissure splint	$106.25
D5988	Surgical splint	$174.25
D5999	Unspecified maxillofacial prosthesis, by report	By Report
	PROSTHODONTICS, FIXED	
D6210	Pontic, cast high noble metal	$178.80
D6211	Pontic, cast predominantly base metal	$178.80
D6212	Pontic, cast noble metal	$178.80
D6240	Pontic, porcelain fused to high noble metal	$178.80
D6241	Pontic, porcelain fused to predominantly base metal	$178.80
D6242	Pontic, porcelain fused to noble metal	$178.80
D6251	Pontic, resin with predominantly base metal	$103.50
D6721	Crown, resin with predominantly base metal	$136.40
D6750	Crown, porcelain fused to high noble metal	$159.95
D6751	Crown, porcelain fused to predominantly base metal	$159.95
D6752	Crown, porcelain fused to noble metal	$159.95
D6790	Crown, full cast high noble metal	$159.95
D6791	Crown, full cast predominantly base metal	$159.95
D6792	Crown, full cast noble metal	$159.95
D6930	Recement fixed partial denture	$32.90
D6972	Prefabricated post and core + retainer	$26.35
D6999	Unspecified fixed prosthodontic procedure, by report	By Report
	ORAL AND MAXILLOFACIAL SURGERY	
D7140	Extraction, Erupted Tooth/Exposed Root	$39.12
D7210	Surgical Removal Of Erupted Tooth	$57.40
D7220	Removal Of Impacted Tooth, Soft Tissue	$66.80
D7230	Removal Of Impacted Tooth, Partially Bony	$86.60
D7240	Removal Of Impacted Tooth, Complete Bony	$100.70
D7250	Surgical Removal Of Residual Tooth Roots	$57.40
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$217.00
D7280	Surgical access of an unerupted tooth	$50.80
D7283	Placement, device to facilitate eruption, impaction	$45.00
D7310	Alveoloplasty with extractions, 4+ teeth, quadrant	$64.00
D7311	Alveoloplasty with extractions, 1-3 teeth, quadrant	$64.00
D7320	Alveoloplasty, w/o extractions, 4+ teeth, quadrant	$64.00
D7321	Alveoloplasty, w/o extractions, 1-3 teeth, quadrant	$64.00
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25	$94.30
D7451	Removal, benign odontogenic cyst/tumor, over 1.25	$199.60
D7460	Removal, benign nonodontogenic cyst/tumor, to 1.25	$94.30
D7461	Removal, benign nonodontogenic cyst/tumor, 1.25+	$199.60
D7510	Incision & drainage of abscess, intraoral soft tissue	$36.70
D7511	Incision/drainage, abscess, intraoral soft, complicated	$36.70
D7610	Maxilla - open reduction (teeth immobilized, if present)	$657.95
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$471.50
D7630	Mandible - open reduction (teeth immobilized, if present)	$824.65

Code	Description of Services	Fee
D7640	Mandible - closed reduction (teeth immobilized, if present)	$706.95
D7710	Maxilla - open reduction	$1,059.35
D7720	Maxilla - closed reduction	$706.35
D7730	Mandible - open reduction	$1,059.35
D7740	Mandible - closed J reduction	$706.20
D7810	Open reduction of dislocation	$438.60
D7820	Closed reduction of dislocation	$177.65
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	$77.15
D7963	Frenuloplasty	$77.15
D7999	Unspecified oral surgery procedure, by report	By Report
	ORTHODONTICS	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$900.00
D8660	Pre-orthodontic treatment visit	$100.00
D8670	Periodic orthodontic treatment visit (as part of contract)	$240.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$150.00
D8999	Unspecified orthodontic procedure, by report	$47.05
	ADJUNCTIVE GENERAL SERVICES	
D9110	Palliative (emergency) treatment, minor procedure	$55.00
D9220	Deep sedation/general anesthesia, 1st 30 minutes	$76.70
D9221	Deep sedation/general anesthesia, each add 'l 15 minutes	$38.35
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$26.00
D9241	Intravenous conscious sedation/analgesia, 1st 30 minutes	$76.70
D9242	IV conscious sedation/analgesia, each add 'l 15 minutes	$38.35
D9248	Non-intravenous conscious sedation	$48.00
D9310	Consultation, Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician	$17.10
D9610	Therapeutic parenteral drug, single admin	By Report
D9630	Other drugs and/or medicaments, by report	$23.50
D9999	Unspecified adjunctive procedure, by report	By Report

2. *Eligibility.* All payments made pursuant to this Addendum are based on Member eligibility at the time services are rendered and on current plan benefits, subject to all limitations and exclusions specified in applicable plan documents.

3. *Claims.* Dental Office is encouraged to submit all claims subject to this Addendum within one hundred and eighty (180) days after the date such services were rendered; provided, however, that Dental Office agrees to submit claims within the time period required by any applicable claims timeliness laws, regulations or rules. Late submissions by Dental Office that do not comport with applicable claims timeliness laws, regulations or rules may, in the sole discretion of LIBERTY, be rejected by LIBERTY.

4. *Term and Termination.* This Addendum shall become effective as of the date specified below by LIBERTY as the "Effective Date" and shall remain in effect until the earlier of either termination of the Agreement in accordance with the terms of the Agreement or termination of this Addendum in accordance with the terms herein. LIBERTY may terminate this Addendum at any time with or without cause by providing at least thirty (30) days' written notice to Dental Office or within the time period required by any applicable timeliness laws, regulations or rules.

[Signatures on next page]

The parties have executed this Addendum as of the Effective Date written below:

("DENTAL OFFICE"):

Authorized Signature

Print Name

Title

Date

Dental Office Address

City, State ZIP

Individual Medicaid Provider Number (if applicable)

Group Medicaid Provider Number (if applicable)

LIBERTY Dental Plan Corporation ("LIBERTY"):

Signature

Print Name

Title

Effective Date

Exhibit A-5

LIBERTY Dental Plan Corporation Provider Agreement
Government Programs
IL-Adult Medicaid FFS Addendum

This IL-Adult Medicaid FFS Addendum (the "Addendum") to the LIBERTY Dental Plan Corporation Provider Agreement (the "Agreement") between LIBERTY Dental Plan Corporation ("LIBERTY," as defined in the Agreement) and the legal entity or individual specified in the Agreement and on the signature page of this Addendum and which/who is qualified and licensed to practice dentistry in the state for which it/he/she is contracted by LIBERTY to perform services ("Dental Office," as further defined in the Agreement) is meant to supplement the Agreement. Except as expressly modified by this Addendum, the Agreement remains in full force and effect and all capitalized terms in this Addendum (which are not otherwise defined) shall have the meaning ascribed to them in the Agreement. LIBERTY and Dentist agree as follows:

1. *Reimbursement/Compensation.* LIBERTY shall pay Dental Office certain Fees for covered Services (whose procedural codes are expressly listed below) that are rendered to eligible Members by qualified dentists in the contracted facilities in accordance with the terms of the Agreement. For purposes of this Addendum, "Fee" is defined as the amount of the applicable fees listed below minus the amount of any applicable Member copayment.

Code	Description of Services	Fee
	DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	$16.20
D0140	Limited oral evaluation - problem focused	$16.20
D0150	Comprehensive oral evaluation - new or established patient	$21.05
D0210	Intraoral - complete series of radiographic images	$30.10
D0220	Intraoral - periapical first radiographic image	$5.60
D0230	Intraoral - periapical each additional radiographic image	$3.80
D0270	Bitewing - single radiographic image	$5.60
D0272	Bitewings - two radiographic images	$9.40
D0274	Bitewings - four radiographic images	$16.90
D0277	Vertical bitewings - 7 to 8 radiographic images	$16.90
D0330	Panoramic radiographic image	$22.60
	PREVENTIVE	
D1110	Prophylaxis – adult	$25.40
	RESTORATIVE	
D2140	Amalgam - one surface, primary or permanent	$30.85
D2150	Amalgam - two surfaces, primary or permanent	$48.15
D2160	Amalgam - three surfaces, primary or permanent	$58.05
D2161	Amalgam - four or more surfaces, primary or permanent	$58.05
D2330	Resin-based composite - one surface, anterior	$34.60
D2331	Resin-based composite - two surfaces, anterior	$51.90
D2332	Resin-based composite - three surfaces, anterior	$61.80
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$61.80
D2391	Resin-based composite - one surface, posterior	$30.85
D2392	Resin-based composite - two surfaces, posterior	$48.15
D2393	Resin-based composite - three surfaces, posterior	$58.05
D2394	Resin-based composite - four or more surfaces, posterior	$58.05
D2740	Crown - porcelain/ceramic substrate	$235.20
D2750	Crown - porcelain fused to high noble metal	$235.20
D2751	Crown - porcelain fused to predominantly base metal	$235.20
D2752	Crown - porcelain fused to noble metal	$235.20
D2790	Crown - full cast high noble metal	$145.85
D2791	Crown - full cast predominantly base metal	$145.85
D2792	Crown - full cast noble metal	$145.85

Code	Description of Services	Fee
D2910	Recement inlay, onlay, or partial coverage restoration	$11.30
D2915	Recement cast or prefabricated post and core	$23.50
D2920	Recement crown	$23.50
D2931	Prefabricated stainless steel crown - permanent tooth	$73.40
D2932	Prefabricated resin crown	$56.45
D2940	Protective restoration	$11.30
D2950	Core buildup, including any pins when required	$58.05
D2951	Pin retention - per tooth, in addition to restoration	$9.40
D2954	Prefabricated post and core in addition to crown	$32.90
	ENDODONTICS	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$136.40
	PERIODONTICS	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$122.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$77.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$62.00
D4910	Periodontal maintenance	$58.00
	PROSTHODONTICS, REMOVED	
D5110	Complete denture - maxillary	$376.35
D5120	Complete denture - mandibular	$376.35
D5130	Immediate denture - maxillary	$376.35
D5140	Immediate denture - mandibular	$376.35
D5510	Repair broken complete denture base	$61.15
D5520	Replace missing or broken teeth - complete denture (each tooth)	$38.10
D5610	Repair resin denture base	$51.75
D5620	Repair cast framework	$79.05
D5630	Repair or replace broken clasp	$71.50
D5640	Replace broken teeth - per tooth	$37.65
D5650	Add tooth to existing partial denture	$42.35
D5730	Reline complete maxillary denture (chairside)	$70.60
D5731	Reline complete mandibular denture (chairside)	$70.60
D5740	Reline maxillary partial denture (chairside)	$70.60
D5741	Reline mandibular partial denture (chairside)	$70.60
D5750	Reline complete maxillary denture (laboratory)	$117.60
D5751	Reline complete mandibular denture (laboratory)	$117.60
D5760	Reline maxillary partial denture (laboratory)	$117.60
D5761	Reline mandibular partial denture (laboratory)	$117.60
D5911	Facial moulage (sectional)	$361.25
D5912	Facial moulage (complete)	$453.90
D5913	Nasal prosthesis	$1,020.00
D5914	Auricular prosthesis	$1,020.00
D5915	Orbital prosthesis	$510.00
D5916	Ocular prosthesis	$1,020.00
D5919	Facial prosthesis	$1,020.00
D5922	Nasal septal prosthesis	$510.00
D5923	Ocular prosthesis, interim	$510.00
D5924	Cranial prosthesis	$1,190.00
D5925	Facial augment implant prosthesis	$255.00
D5926	Cranial prosthesis	$255.00
D5927	Auricular prosthesis, replacement	$255.00
D5928	Orbital prosthesis, replacement	$255.00

Code	Description of Services	Fee
D5929	Facial prosthesis, replacement	$255.00
D5931	Obturator prosthesis, surgical	$850.00
D5932	Obturator prosthesis, definitive	$1,275.00
D5933	Obturator prosthesis, modification	$191.25
D5934	Mandibular resection prosthesis with guide flange	$1,445.00
D5935	Mandibular resection prosthesis without guide flange	$1,190.00
D5936	Obturator prosthesis, interim	$765.00
D5937	Trismus appliance (not for TMD treatment)	$106.25
D5951	Feeding aid	$170.00
D5953	Speech aid prosthesis, adult	$1,232.50
D5954	Palatal augmentation prosthesis	$170.00
D5955	Palatal lift prosthesis, definitive	$1,190.00
D5958	Palatal lift prosthesis, interim	$680.00
D5959	Palatal lift prosthesis, modification	$187.00
D5960	Speech aid prosthesis, modification	$187.00
D5982	Surgical stent	$106.25
D5983	Radiation carrier	$68.00
D5984	Radiation shield	$170.00
D5985	Radiation cone locator	$170.00
D5986	Fluoride gel carrier	$68.00
D5987	Commissure splint	$106.25
D5988	Surgical splint	$174.25
D5999	Unspecified maxillofacial prosthesis, by report	By Report
	PROSTHODONTICS, FIXED	
D6930	Recement fixed partial denture	$32.90
D6999	Unspecified fixed prosthodontic procedure, by report	By Report
	ORAL AND MAXILLOFACIAL SURGERY	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$39.12
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevetion of mucoperiosteal flap if indicated	$57.40
D7220	Removal of impacted tooth - soft tissue	$66.80
D7230	Removal of impacted tooth - partially bony	$86.60
D7240	Removal of impacted tooth - completely bony	$100.70
D7250	Surgical removal of residual tooth roots (cutting procedure)	$57.40
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$94.30
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$199.60
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$94.30
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$199.60
D7510	Incision and drainage of abscess - intraoral soft tissue	$36.70
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$36.70
D7610	Maxilla - open reduction (teeth immobilized, if present)	$657.95
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$471.50
D7630	Mandible - open reduction (teeth immobilized, if present)	$824.65
D7640	Mandible - closed reduction (teeth immobilized, if present)	$706.95
D7710	Maxilla - open reduction	$1,059.35
D7720	Maxilla - closed reduction	$706.35
D7730	Mandible - open reduction	$1,059.35
D7740	Mandible - closed J reduction	$706.20
D7810	Open reduction of dislocation	$438.60
D7820	Closed reduction of dislocation	$177.65

Code	Description of Services	Fee
D7999	Unspecified oral surgery procedure, by report	By Report
	ADJUNCTIVE GENERAL SERVICES	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$55.00
D9220	Deep sedation/general anesthesia - first 30 minutes	$76.70
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$38.35
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$26.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$76.70
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$38.35
D9248	Non-intravenous conscious sedation	$48.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$17.10
D9610	Therapeutic parenteral drug, single administration	By Report
D9630	Other drugs and/or medicaments, by report	$23.50
D9999	Unspecified adjunctive procedure, by report	By Report

2. *Eligibility.* All payments made pursuant to this Addendum are based on Member eligibility at the time services are rendered and on current plan benefits, subject to all limitations and exclusions specified in applicable plan documents.

3. *Claims.* Dental Office is encouraged to submit all claims subject to this Addendum within one hundred and eighty (180) days after the date such services were rendered; provided, however, that Dental Office agrees to submit claims within the time period required by any applicable claims timeliness laws, regulations or rules. Late submissions by Dental Office that do not comport with applicable claims timeliness laws, regulations or rules may, in the sole discretion of LIBERTY, be rejected by LIBERTY.

4. *Term and Termination.* This Addendum shall become effective as of the date specified below by LIBERTY as the "Effective Date" and shall remain in effect until the earlier of either termination of the Agreement in accordance with the terms of the Agreement or termination of this Addendum in accordance with the terms herein. LIBERTY may terminate this Addendum at any time with or without cause by providing at least thirty (30) days' written notice to Dental Office or within the time period required by any applicable timeliness laws, regulations or rules.

The parties have executed this Addendum as of the Effective Date written below:

("DENTAL OFFICE"):

____
Authorized Signature

____
Print Name

____
Title

____
Date

____
Dental Office Address

____
City, State ZIP

____
Individual Medicaid Provider Number (if applicable)

____
Group Medicaid Provider Number (if applicable)

LIBERTY Dental Plan Corporation ("LIBERTY"):

____
Signature

____
Print Name

____
Title

____
Effective Date

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

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 the "Name" line 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.

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

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

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. citizen or other U.S. person (defined below).

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.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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.

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. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

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.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

Illinois Provider Credentialing Application

It is required that you include the following documentation with your contracting documents to become a LIBERTY Dental Plan provider. Individual Provider Credentialing Applications are necessary for the Practice Owner and for each Associate Dentist rendering services.

The State of Illinois Health Care Professional Credentialing and Business Gathering Form has been adopted by the State of Illinois to be used by multiple health care entities. It is only necessary to complete the following pages for LIBERTY'S credentialing process:

- **Page 2 -** Sign and Date
- **Pages 3** (including SSN)**, 4, 5**
- **Page 7**
- **Page 9**
- **Page 16** (Work History for Past 5 Years – must include month/year)
- **Page 19, 20, 21, 22**
- **Page 23** (Bottom Half)
- **Page 25** (Tax ID Info)
- **Page 26, 27** (Only complete if you have additional locations)

Include current copies of the following:

- **Dental License**
- **DEA**
- **Malpractice Insurance (Declaration Page)**
- **Specialty Certificate** (if applicable)

STATE OF ILLINOIS

Health Care Professional Credentialing and Business Data Gathering Form

The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care plans which desire to credential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

INSTRUCTIONS

This form is for initial credentialing only. Other forms are required for recredentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED BY THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR REQUIREMENTS.

This form has been segmented into two (2) different Chapters, each containing various sections:

Chapter A: Practice and Professional Information
Chapter B: Business Information

As previously noted, please consult the specific credentialing entity instructions for their individual Chapter or Section requirements for submission.

GENERAL INSTRUCTIONS: Wherever this application requests information but does not provide sufficient space to provide a complete response (for example, you have more licenses, specialties, work history, etc.) provide attachments which contain all of the information requested in the relevant section OR duplicate the relevant section as many times as necessary and attach it to the back of this application.

The data marked as "Confidential Information" shall be maintained in confidence to the extent required by law. They may be used by the health care plan, entity or hospital and by their agents for credentialing and internal business purposes. Other data contained in this form may be released.

ATTACHMENTS

Attach forms A-F as needed to support "yes" responses in Section J: Professional History and copies of the following:

- ☐ Curriculum Vitae

CONFIDENTIAL INFORMATION:

- ☐ All Current Professional Licenses
- ☐ Current Federal DEA License, If Applicable
- ☐ Current State Controlled Substance License(s), If Applicable
- ☐ Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate
- ☐ Current CLIA Certificate, If Applicable
- ☐ Current W-9s, If Applicable
- ☐ ECFMG Certificate, If Applicable
- ☐ •Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, As Applicable

AFFIRMATION OF INFORMATION

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Health Care Professional Credentialing and Business Data Gathering Update Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

______________________	______________________	__________
Applicant's Signature	Type or Print Name	Date

** ***PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY,*** **
** ***AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN*** **
** ***ATTESTATION AND RELEASE OF INFORMATION FORM.*** **

CHAPTER A:
PRACTICE AND PROFESSIONAL INFORMATION

SECTION A. GENERAL INFORMATION

Name: ______________________________
Last First MI Degree

List other names by which you have been known: ______________________________
Last First MI

If you have been known by other names, please explain why your name changed:

____

____

Birth Date: __________ Place of Birth: ______________________________
(mm/dd/yy) City State Country

Sex: ☐ Male ☐ Female Language Fluency of Applicant: ☐ English ☐• Other: __________

U.S. Citizen? ☐ Yes ☐ No ☐ Spanish

If no, do you have a legal right to reside permanently and work in the U.S.? ☐ Yes ☐ No

CONFIDENTIAL INFORMATION

Resident Visa No: __________

Social Security Number: __________

Emergency Contact Person: ______________________________
Last First MI

Telephone Number: ( ) __________

Mailing Address: ______________________________
Street City State Zip

Daytime Phone: ( ) __________ Fax Number: ( ) __________

E-Mail Address: __________

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION B. PROFESSIONAL INFORMATION

Illinois Professional License Number: ____________________

License Unlimited? Yes ☐ No ☐ ➡ If No, please explain limitation: ____________________

____

Current and Previous Professional License(s) in Other States

State: ____________ License #: ____________ Exp. Date: ________ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ ➡ If No, please explain limitation: ____________________

____

State: ____________ License #: ____________ Exp. Date: ________ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ ➡ If No, please explain limitation: ____________________

____

State: ____________ License #: ____________ Exp. Date: ________ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ ➡ If No, please explain limitation: ____________________

____

Check here if you have appended additional information for this section: ☐

Current Federal DEA License Number: ____________________ ***CONFIDENTIAL INFORMATION***

DEA License Number Expiration Date: ____________________ License Unlimited? Yes ☐ No ☐

If No, please explain limitation: ____________________

____

Check here if you have appended additional information for this section: ☐

Current and Previous State Controlled Substance Number(s):

CONFIDENTIAL INFORMATION

State:	CS License #:	Expiration Date:
____________	____________	________ (mm/dd/yy)
____________	____________	________ (mm/dd/yy)
____________	____________	________ (mm/dd/yy)

Please identify all limitation related to the above Controlled Substances Number(s) and explain limitation.

____

____

Medicare Unique Provider ID# (UPIN): ______________________

National Provider Identification Number (NPI): ______________________

Medicaid ID#: ______________________

X-Ray Certification: State: __________ Certificate #: __________ Expiration Date: __________ (mm/dd/yy)

Check here if you have appended additional information for this section: ☐

COMPLETE FOR EACH SPECIALTY

Specialty I: ______________________

Are you Board Certified in Specialty I? Yes ☐ No ☐

If Yes, name of Certifying Board: ______________________

Date of Certification: __________ (mm/yy) Date of Recertification (if applicable): __________ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: __________ (mm/yy) Certification Expiration Date, if Any: __________ (mm/yy)

If not taken, date scheduled to take Specialty Boards: __________ (mm/yy)

Specialty/Subspecialty II: ______________________

Are you Board Certified in Specialty II? Yes ☐ No ☐

If Yes, name of Certifying Board: ______________________

Date of Certification: __________ (mm/yy) Date of Recertification (if applicable): __________ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: __________ (mm/yy) Certification Expiration Date, if Any: __________ (mm/yy)

If not taken, date scheduled to take Specialty Boards: __________ (mm/yy)

(Please continue next page)

Specialty/Subspecialty III: ______________________________

Are you Board Certified in Specialty III? Yes ☐ No ☐

If Yes, name of Certifying Board: ______________________________

Date of Certification: ____________ (mm/yy) Date of Recertification (if applicable): ____________ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: ____________ (mm/yy) Certification Expiration Date, if Any: ____________ (mm/yy)

If not taken, date scheduled to take Specialty Boards: ____________ (mm/yy)

Specialty/Subspecialty IV: ______________________________

Are you Board Certified in Specialty IV? Yes ☐ No ☐

If Yes, name of Certifying Board: ______________________________

Date of Certification: ____________ (mm/yy) Date of Recertification (if applicable): ____________ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: ____________ (mm/yy) Certification Expiration Date, if Any: ____________ (mm/yy)

If not taken, date scheduled to take Specialty Boards: ____________ (mm/yy)

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past 10 years.

CURRENT PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: ______________________________

Address: ______________________________
Street City State Zip

Policy Number: __________ Original Effective Date: __________ Expiration Date: __________
(mm/dd/yy) (mm/dd/yy)

Policy Limits: Per Occurrence: $__________ Aggregate: $__________

Retroactive Date: __________
(mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: ______________________________

Address: ______________________________
Street City State Zip

Policy Number: __________ Original Effective Date: __________ Expiration Date: __________
(mm/dd/yy) (mm/dd/yy)

Policy Limits: Per Occurrence: $__________ Aggregate: $__________

Retroactive Date: __________
(mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: ______________________________

Address: ______________________________
Street City State Zip

Policy Number: ____________ Original Effective Date: ________ (mm/dd/yy) Expiration Date: ________ (mm/dd/yy)

Policy Limits: Per Occurrence: $ ________ Aggregate: $ ________

Retroactive Date: ________ (mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: ______________________________

Address: ______________________________
Street City State Zip

Policy Number: ____________ Original Effective Date: ________ (mm/dd/yy) Expiration Date: ________ (mm/dd/yy)

Policy Limits: Per Occurrence: $ ________ Aggregate: $ ________

Retroactive Date: ________ (mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

Check here if you have appended additional information for this section: ☐

SECTION D. EDUCATION AND TRAINING

If there are any gaps in your training (greater than 30 days), or if you have not completed any portion of your training, please explain on a separate sheet of paper and attach to this application.

MEDICAL/PROFESSIONAL SCHOOL

Institution Name: ______________________________

Mailing Address: ______________________________
Street City State Zip

Telephone Number: (   ) __________ Fax Number: (   ) __________

Degree: __________ Year Graduated: __________

Dates attended: From: __________ To: __________
mm/yy mm/yy

If you are a graduate of a foreign medical school, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No

Date Issued: __________ Serial Number for ECFMG: __________
mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

If you attended more than one medical/professional school, please check here and attach an explanation that duplicates the information requested above: ☐•

•

INTERNSHIP

Institution Name: ______________________________

Department Chair or Program Director: ______________________________
Last Name First Name MI Degree

Mailing Address: ______________________________
Street City State Zip

Telephone Number: (   ) __________ Fax Number: (   ) __________

Dates attended: From: __________ To: __________
mm/yy mm/yy

Type of internship: ☐ Rotating ☐ Straight → If straight, please list specialty: __________

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

If more than one internship, please check here and attach additional information that duplicates the information requested above: ☐

FIRST RESIDENCY

Institution Name:____

Department Chair or Program Director: _________________________________
Last Name First Name MI Degree

Mailing Address:____
Street City State Zip

Telephone Number: (___)____________ Fax Number: (___)____________

Dates attended: From:__________ To:__________
mm/yy mm/yy

Type of residency:__________________________

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

SECOND RESIDENCY

Institution Name:____

Department Chair or Program Director: _________________________________
Last Name First Name MI Degree

Mailing Address:____
Street City State Zip

Telephone Number: (___)____________ Fax Number: (___)____________

Dates attended: From:__________ To:__________
mm/yy mm/yy

Type of residency:__________________________

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

If more than two residencies, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

FIRST FELLOWSHIP

Institution Name:____

Department Chair or Program Director: ______________________________

Last Name First Name MI Degree

Mailing Address:____

Street City State Zip

Telephone Number: (___)____________ Fax Number: (___)____________

Dates attended: From:__________ To:__________

mm/yy mm/yy

Type of fellowship:____________________________

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a “Yes” answer.) ←

SECOND FELLOWSHIP

Institution Name:____

Department Chair or Program Director: ______________________________

Last Name First Name MI Degree

Mailing Address:____

Street City State Zip

Telephone Number: (___)____________ Fax Number: (___)____________

Dates attended: From:__________ To:__________

mm/yy mm/yy

Type of fellowship:____________________________

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a “Yes” answer.) ←

If more than two fellowships, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (MOST RECENT)

Institution Name:____

Department Chair or Program Director: ____
Last Name First Name MI Degree

Mailing Address:____
Street City State Zip

Telephone Number: (   )__________ Fax Number: (   )__________

Dates: From:________ To:________ Rank/Position, if applicable:________________
mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (PREVIOUS)

Institution Name:____

Department Chair or Program Director: ____
Last Name First Name MI Degree

Mailing Address:____
Street City State Zip

Telephone Number: (   )__________ Fax Number: (   )__________

Dates: From:________ To:________ Rank/Position, if applicable:________________
mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

If more than two teaching experiences/faculty appointments, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

•

MEMBERSHIP STATUS – USE FOR SECTIONS E, F, AND G

Please use the following key to indicate membership status in Sections E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgery Center Practice) below.

A. Active	E. Suspended / Terminated/ Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct	H. Associate	L. Other (Specify)

SECTION E. HOSPITAL MEMBERSHIP - CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (Include additional sheets if more than three hospitals.)

A. Primary Hospital

Hospital Name: ______________________________

Address: ______________________________
Street City State Zip

Membership Status: ______________ Dates: ______________ **To Present**
From (mm/yy)

Department/Division: ______________ Medical Staff Office FAX #: ( ) ______________

Department Telephone #: ( ) ______________

Any Limitations in Your Area of Specialty at this Hospital? ______________

____

B. Other Hospital

Hospital Name: ______________________________

Address: ______________________________
Street City State Zip

Membership Status: ______________ Dates: ______________ To: ______________
From (mm/yy) To (mm/yy)

Department/Division: ______________ Medical Staff Office FAX #: ( ) ______________

Department Telephone #: ( ) ______________

Any Limitations in Your Area of Specialty at this Hospital? ______________

____

C. Other Hospital

Hospital Name: ____________________

Address: ____________________
Street City State Zip

Membership Status: ____________ Dates: ________ To: ________
From (mm/yy) To (mm/yy)

Department/Division: ____________ Medical Staff Office FAX #: (   ) ________

Department Telephone #: (   ) ________

Any Limitations in Your Area of Specialty at this Hospital? ____________

____

Check here if you have appended additional information for this section: ☐

SECTION F. HOSPITAL MEMBERSHIP – PREVIOUS

Please list all hospitals where you previously held privileges other than during your Internship/Residency/Fellowship. Use the Membership Status key listed prior to Section E. (Include additional sheets if more than three hospitals.)

A. Hospital Name: ____________________

Address: ____________________
Street City State Zip

Membership Status: ____________ Dates: ________ To: ________
From (mm/yy) To (mm/yy)

Department/Division: ____________ Medical Staff Office FAX #: (   ) ________

Department Telephone #: (   ) ________

Any Limitations in Your Area of Specialty at this Hospital? ____________

____

B. Hospital Name: ____________________

Address: ____________________
Street City State Zip

Membership Status: ____________ Dates: ________ To: ________
From (mm/yy) To (mm/yy)

Department/Division: ____________ Medical Staff Office FAX #: (   ) ________

Department Telephone #: (   ) ________

Any Limitations in Your Area of Specialty at this Hospital? ____________

____

C. Hospital Name: ______________________________

Address: ______________________________
Street City State Zip

Membership Status: ______________ Dates: ________ To: ________
From (mm/yy) To (mm/yy)

Department/Division: ______________ Medical Staff Office FAX #: ( )

Department Telephone #: ( )

Any Limitations in Your Area of Specialty at this Hospital? ______________

____

Check here if you have appended additional information for this section: ☐

SECTION G. AMBULATORY SURGERY CENTER PRACTICE

Please list all ambulatory surgery centers where you currently have or previously had privileges. Use the Membership Status key at the top of page 13. (Include additional sheets if more than three ambulatory surgery centers.)

A. Primary Ambulatory Surgery Center

ASC Name: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) Fax Number: ( )

Membership Status: ______________ Dates: ________ To: ________
From (mm/yy) To (mm/yy)

B. Other Ambulatory Surgery Center

ASC Name: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) Fax Number: ( )

Membership Status: ______________ Dates: ________ To: ________
From (mm/yy) To (mm/yy)

C. Other Ambulatory Surgery Center

ASC Name: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) Fax Number: ( )

Membership Status: ______________ Dates: ________ To: ________
From (mm/yy) To (mm/yy)

Check here if you have appended additional information for this section: ☐

SECTION H. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service). Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) __________ Fax Number: ( ) __________

Title or Professional Occupation: ______________________________

Time in this employment: From: __________ **to Present**
(mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) __________ Fax Number: ( ) __________

Title or Professional Occupation: ______________________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) __________ Fax Number: ( ) __________

Title or Professional Occupation: ______________________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) __________ Fax Number: ( ) __________

Title or Professional Occupation: ______________________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) __________ Fax Number: ( ) __________

Title or Professional Occupation: ______________________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: (   ) ________ Fax Number: (   ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: (   ) ________ Fax Number: (   ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: (   ) ________ Fax Number: (   ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: (   ) ________ Fax Number: (   ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge (within the past 12 months) of your current clinical abilities, ethical character and interpersonal skills and who would be willing to provide this information upon request. Do not list partners or department chairpersons. Do not list relatives or people listed elsewhere in this credentialing form.

CONFIDENTIAL INFORMATION

1. **Name**: ______________________________ Title: __________
   Last First MI Degree

   Specialty: ______________________________

   Mailing Address: ______________________________
   Street City State Zip

   Telephone: ( ) __________ Fax Number: ( ) __________

   Relationship: ______________________________ Years Known: __________

2. **Name**: ______________________________ Title: __________
   Last First MI Degree

   Specialty: ______________________________

   Mailing Address: ______________________________
   Street City State Zip

   Telephone: ( ) __________ Fax Number: ( ) __________

   Relationship: ______________________________ Years Known: __________

3. **Name**: ______________________________ Title: __________
   Last First MI Degree

   Specialty: ______________________________

   Mailing Address: ______________________________
   Street City State Zip

   Telephone: ( ) __________ Fax Number: ( ) __________

   Relationship: ______________________________ Years Known: __________

(Please continue next page)

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No

2. Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? ☐ Yes ☐ No
?

3. Have you lost any board certification(s), and/or failed to recertify? ☐ Yes ☐ No

4. Have you been examined by a Certifying Board but failed to pass? ☐ Yes ☐ No

5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? ☐ Yes ☐ No

6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?? ☐ Yes ☐ No

7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? ☐ Yes ☐ No

8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No

9 Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license?? ☐ Yes ☐ No

10. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs?? ☐ Yes ☐ No

11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues?? ☐ Yes ☐ No

12. Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?? ☐ Yes ☐ No

13. Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision? ☐ Yes ☐ No

PROFESSIONAL LIABILITY ACTIONS

If you answer yes to any question(s) in this section please complete FORM B. Please make copies of FORM B if needed, and complete one for each yes answer.

1. Have any professional liability judgments ever been entered against you? ☐ Yes ☐ No
2. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf? ☐ Yes ☐ No
3. Are there any currently pending professional liability suits, actions and/or claims filed against you? ☐ Yes ☐ No
4. Has any person or entity ever been sued for your clinical actions? ☐ Yes ☐ No

LIABILITY INSURANCE

If you answer yes to this question please complete FORM C.

Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced ? ☐ Yes ☐ No

CRIMINAL ACTIONS

If you answer yes to any question(s) in this section please complete FORM D. Please make copies of FORM D if needed, and complete one for each yes answer.

1. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? ☐ Yes ☐ No
2. Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse? ☐ Yes ☐ No

MEDICAL CONDITION

If you answer yes to this question please complete FORM E.

Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No

CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

If you answer yes to any question(s) in this section please complete FORM F. Please make copies of FORM F if needed, and complete one for each yes answer.

1. Are you currently engaged in illegal use of any legal or illegal substances? ☐ Yes ☐ No
2. Do you currently overuse and/or abuse alcohol or any other controlled substances? ☐ Yes ☐ No
3. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No
4. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse? ☐ Yes ☐ No

INVESTMENTS

In the last five (5) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies? ☐ Yes ☐ No

If Yes, please provide explanation: ____________________

____

____

____

____

(Please continue next page)

CHAPTER B:
BUSINESS INFORMATION

SECTION K. PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

Primary Site

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

( ) Main Telephone Number

Office Administrator – Last First MI

( ) Beeper Number

( ) FAX Number

E-mail

( ) Emergency Number

( ) Answering Service

Specialty practiced at this site:

Is your practice restricted within your specialty (e.g., by age or type of patient)? ☐ Yes ☐ No

If yes, describe the restrictions:

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If yes, describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site:

Please provide the number of patient visits you have at this site per year:

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour		
Average Waiting Time in Office (from scheduled appointment time to actual examination)		
Average Response Time for Returning Patient Calls:	Acute or Urgent Situation:	
	Emergency Situation:	
	Routine Call:	

Please check all procedures you perform at this site:

☐ Age-appropriate immunizations	☐ EKG	☐ Drawing blood
☐ Tympanometry/audiometry screening	☐ X-rays	☐ Minor surgery
☐ Pulmonary function studies	☐ Flexible sigmoidoscopy	☐ Laceration repair
☐ Office gynecology (routine pelvic/PAP)	☐ Asthma treatment	☐ Allergy skin testing
☐ Osteopathic /Chiropractic manipulation	☐ IV hydration/treatment	☐ Physical Therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: ____________________

Special Skills of Staff: ____________________

Languages Spoken by Practitioner: ____________________

Languages Written by Practitioner: ____________________

Languages Spoken by Staff: ____________________

Languages Written by Staff: ____________________

Is this practice site handicapped accessible (check all that apply)?

☐ Building ☐ Parking ☐ Wheelchair ☐ Restroom

Does this site employ paraprofessionals for direct patient care? ☐ Yes ☐ No

If yes, is supervision always provided on premises during paraprofessionals' direct patient care?

☐ Yes ☐ No

Do the paraprofessional(s) bill under any of your Tax ID Numbers? ☐ Yes ☐ No

If yes, list Tax ID Numbers used: ***CONFIDENTIAL INFORMATION***

____________________ ____________________ ____________________

Lab Service at this site? ☐ Yes ☐ No

If yes, check whether: ☐ Primary ☐ Secondary ☐ Tertiary

CLIA Waiver: ☐ Yes ☐ No

If yes, CLIA Expiration Date: ________________

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

Name: ____
Last First MI Degree

Specialty: ____________________________

Address: ____________________________ Telephone: ( ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Name: ____
Last First MI Degree

Specialty: ____________________________

Address: ____________________________ Telephone: ( ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Name: ____
Last First MI Degree

Specialty: ____________________________

Address: ____________________________ Telephone: ( ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name: ____________________________ Specialty: ______________
Last First MI

Name: ____________________________ Specialty: ______________
Last First MI

Name: ____________________________ Specialty: ______________
Last First MI

SECTION L. PRIMARY SITE TAX INFORMATION

Please provide the following information for your Primary Site. Include tax information for each business arrangement you use at this site. (Please include additional sheets if more than four applicable business arrangements.)

Business Arrangement #1

Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (___) ______________

Business Arrangement #2

Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (___) ______________

Business Arrangement #3

Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (___) ______________

Business Arrangement #4

Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (___) ______________

SECTION M. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice.

Site
#

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

( )
Main Telephone Number

Office Administrator – Last First MI

( )
Beeper Number

( )
FAX Number

E-mail

( )
Emergency Number

( )
Answering Service

Specialty practiced at this site:

Is your practice restricted within your specialty (e.g., by age or type of patient)? ☐ Yes ☐ No

If yes, describe the restrictions:

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If yes, describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site:

Please provide the number of patient visits you have at this site per year:

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Hours	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour		
Average Waiting Time in Office (from scheduled appointment time to actual examination)		
Average Response Time for Returning Patient Calls:	Acute or Urgent Situation:	
	Emergency Situation:	
	Routine Call:	

Please check all procedures you perform at this site:

☐ Age-appropriate immunizations	☐ EKG	☐ Drawing blood
☐ Tympanometry/audiometry screening	☐ X-rays	☐ Minor surgery
☐ Pulmonary function studies	☐ Flexible sigmoidoscopy	☐ Laceration repair
☐ Office gynecology (routine pelvic/PAP)	☐ Asthma treatment	☐ Allergy skin testing
☐ Osteopathic /Chiropractic manipulation	☐ IV hydration/treatment	☐ Physical Therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: ______________________________

Special Skills of Staff: ______________________________

Languages Spoken by Practitioner: ______________________________

Languages Written by Practitioner: ______________________________

Languages Spoken by Staff: ______________________________

Languages Written by Staff: ______________________________

Is this practice site handicapped accessible (check all that apply)?

☐ Building ☐ Parking ☐ Wheelchair ☐ Restroom

Does this site employ paraprofessionals for direct patient care? ☐ Yes ☐ No

If yes, is supervision always provided on premises during paraprofessionals' direct patient care?

☐ Yes ☐ No

Do the paraprofessional(s) bill under any of your Tax ID Numbers? ☐ Yes ☐ No

If yes, list Tax ID Numbers used: ***CONFIDENTIAL INFORMATION***

______________________ ______________________ ______________________

Lab Service at this site? ☐ Yes ☐ No

If yes, check whether: ☐ Primary ☐ Secondary ☐ Tertiary

CLIA Waiver: ☐ Yes ☐ No

If yes, CLIA Expiration Date: ________________

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

Name: ____
Last First MI Degree

Specialty: ______________________________

Address: ______________________________ Telephone: ( ) ________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Name: ____
Last First MI Degree

Specialty: ______________________________

Address: ______________________________ Telephone: ( ) ________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Name: ____
Last First MI Degree

Specialty: ______________________________

Address: ______________________________ Telephone: ( ) ________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name: ______________________________ Specialty: ________________
Last First MI

Name: ______________________________ Specialty: ________________
Last First MI

Name: ______________________________ Specialty: ________________
Last First MI

SECTION N. ADDITIONAL SITE TAX INFORMATION

Please provide the following information for each additional site at which you practice. Include tax information for each business arrangement you use at this site. (If there is more than one additional site, or more than five business arrangements at any one site, please copy and complete this page for each additional site and business arrangement.)

Business Arrangement #1
Name of Business Arrangement On SS4 or W-9 Form: ____________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ____________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ____________________

Telephone Number, if Different from Primary Site: ( ) ____________________

Business Arrangement #2
Name of Business Arrangement On SS4 or W-9 Form: ____________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ____________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ____________________

Telephone Number, if Different from Primary Site: ( ) ____________________

Business Arrangement #3
Name of Business Arrangement On SS4 or W-9 Form: ____________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ____________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ____________________

Telephone Number, if Different from Primary Site: ( ) ____________________

Business Arrangement #4
Name of Business Arrangement On SS4 or W-9 Form: ____________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ____________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ____________________

Telephone Number, if Different from Primary Site: ( ) ____________________

End Credentialing and Business Data Gathering Form.
Attach Forms A-F As Required.

FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.

Applicant Name:____
Last First MI

Indicate the number of ONE of the questions in Section J to which you answered "yes": Question Number: ____

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

B. Provide an explanation of any actions taken. Please include the date the action was taken.

C. Provide the current status of the issue.

D. If known: Contact: ____________________________________

Department/Committee: ____________________________________

Address: ____
Street City State Zip

Telephone: ( ) ________________

Signature:____ **Date:**________________

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: ______________________________
Last First MI

A. Plaintiff's Name: ______________________________
Last First MI

If court case, Case Name & Case Number: ______________________________

____

B. Your Involvement in the Care (Attending, Consulting, Etc.): ______________________________

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): ______________________________

D. Allegations, including Patient Outcome, if Available: ______________________________

____

____

____

E. Date of Incident (mm/yy): ____________ F. Date Filed (mm/yy): ____________

G. Date Case Closed (mm/yy): ____________

Resolution Case: ☐ Dismissed ☐ Settlement out of Court ☐ Judgment ☐ Pending ☐ Arbitration ☐ Mediation ☐ Other

H. Amount Paid on Your Behalf (if any): $____________

I. Professional Liability Insurer Name (if one was involved): ______________________________

J. Insurer Telephone Number: ( ) ____________ K. Policy Number: ____________

L. Insurer Address (Street, City, State, Zip Code):

____

____

Signature: ______________________________ **Date:** ____________

•

FORM C – LIABILITY INSURANCE

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: ______________________________
Last First MI

A. **History of Professional Liability Insurance (Please check One)**

☐ Canceled Voluntarily ☐ Non-Renewed

☐ Canceled Involuntarily ☐ Application Denied

B. Carrier Name: ______________________________

C. Carrier Telephone Number: (___) ______________

D. Policy Number: ______________

E. Carrier Address (Street, City, State, Zip Code):

____

____

F. Dates of Coverage: From (mm/yy): __________ To (mm/yy): __________

G. Circumstances Involved: ______________________________

____

Signature: ______________________________ **Date:** ______________

FORM D – CRIMINAL ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH incident. Use reverse side of this form if additional space is needed.

Applicant Name: ______________________________

Last First MI

A. Date of Incident (mm/yy): __________

B. Date of Complaint or Conviction (mm/yy): __________

C. Date of Resolution (mm/yy): __________

D. Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony): __________

E. Allegation(s): __________

F. Details of Incident: __________

G. Actions Taken Against You: __________

H. Current Status of Situation: __________

I. Medical Practice Privileges Affected as a Result of This Situation: __________

Signature: __________ **Date:** __________

FORM E – MEDICAL CONDITION

DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

Applicant Name: ____
Last First MI

A. Describe this medical condition: ____

B. To what extent does or could this condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

C. What is the current status of your condition? ____

D. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

Name				**Telephone Number**
Last	First	MI	Degree	( )
Last	First	MI	Degree	( )

Signature: ______________________________ **Date:** ______________

FORM F – CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

DUPLICATE this form as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.

Applicant Name:____
Last First MI

Describe the substance you use:

____

A. To what extent does, or could, your use of this substance affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

____

____

B. Monitored by State Board Mandate (Name and Address)

C. Monitored Voluntarily (Name and Address)

D. Other information about the current status of your use of substances:

____

____

E. Abstinent since (mm/yy):____________

F. Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance use and can comment on what impact (if any) it has on your current/future professional practice.

Name:____________________________________

Address: ____
Street City State Zip

Telephone: ( )__________

Signature:________________________________ **Date:**______________