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

Owner – Per Facility/Location

(All Facility/Location documents signed by Owner/CEO, CFO, VP, or Dental Director)

- ❑ Facility Application Per Location
  (One set of documents per location)
- ❑ Provider Agreement
  (Must be signed by authorized signatory – Owner, CEO, VP, etc.)
- ❑ Medicaid and/or Medicare Addenda
  (Must be signed by authorized signatory if applicable)
- ❑ Fee Schedule Addenda
  (Must be signed by authorized signatory)
- ❑ W-9
  (Must use the address registered with the IRS as your corporate billing address for multiple locations with the same tax ID #. Must be signed by authorized signatory.)
- ❑ Electronic Fund Transfer Form
  (If applicable)
- ❑ Provider Compliance Attestation

Owner & Associates

- ❑ Provider Credentialing Application
  (One credentialing application must be completed and signed for each Dentist rendering services.)
- ❑ Current Dental license
- ❑ Current Federal DEA certificate or waiver
- ❑ Current malpractice insurance certificate declaration page showing professional liability
- ❑ Copy of Specialty Certificate
  (If applicable)
- ❑ Copy of internship/residency/ fellowship certificate
  (If applicable)
- ❑ Copy of Board Certification
  (If applicable)

Services rendered prior to the receipt of the Welcome Letter reflecting an Effective Date will be denied.

The items listed above are required and must accompany this application. Failure to do so may delay the processing of your application. Please email the completed application to prnational@libertydentalplan.com or mail to:

LIBERTY Dental Plan
PO Box 15149
Tampa, FL 33684

If you have any questions regarding the contracting process, please contact Professional Relations at (888) 352-7924.

FACILITY APPLICATION *(Complete one application per facility)*

Facility Information

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): _____ **CONTACT NAME:** _____

ALTERNATE MAILING ADDRESS: *(if different from practice address)*

☐ PAYMENT REMITTANCE ☐ CORRESPONDENCE

_____
Street Address *Suite/Unit #*

_____
City *State* *ZIP Code*

LANGUAGES SPOKEN: _____

RECALL METHOD USED: _____

PRIMARY DENTIST:	_____	☐ **DDS**	☐ **DMD**	☐ **Other**	_____
ASSOCIATE DENTIST:	_____	☐ **DDS**	☐ **DMD**	☐ **Other**	_____
ASSOCIATE DENTIST:	_____	☐ **DDS**	☐ **DMD**	☐ **Other**	_____
ASSOCIATE DENTIST:	_____	☐ **DDS**	☐ **DMD**	☐ **Other**	_____

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** **Special Needs** ☐ **Yes** ☐ **No**

What type of emergency contact system is used? _____

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

Age range of patients seen? ☐ **All Ages** ☐ **0 – 21**

Minimum Treatment Age: _____ ☐ **Other:** _____

Hours of Operation

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 _____ **days**

Hygiene _____ **days**

Routine _____ **days**

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 further defined below, "LIBERTY") and [LEGAL NAME OF DENTAL OFFICE]: _____ ("Dental Office"), a(n) [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 arranges for the provision of certain dental services to Members (as defined below);

WHEREAS, Dental Office desires to provide such dental services to Members upon the terms and conditions of this Agreement;

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 that contains all information necessary for LIBERTY to process the claim and that meets all applicable criteria and requirements set forth in the Provider Manual and applicable law.

"Continuation of Care" means the obligation of Dental Office to provide services to a Member beyond the termination date of this Agreement, as set forth in Section 4.3(b).

"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 eligible to receive under the applicable Dental Plan, as set forth in the Plan Description, subject to applicable laws governing covered services.

"Dental Director" means the individual or group of individuals appointed by LIBERTY to establish, monitor and maintain professional standards for Dentists.

"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. Only those Dental Office locations approved in writing, and linked to this Agreement, by LIBERTY shall be permitted to render dental services to Members.

"Dental Office Agent" means an agent or representative of Dental Office (including, but not limited to, Dentists, dental hygienists, assistants, staff members, contractors, or any other individuals acting at the direction or under the control of Dental Office) performing any services pursuant to this Agreement.

"Dental Plan" means dental coverage provided by LIBERTY or a Payor (defined below), in which Dental Office and Dentists are eligible, and selected and approved by LIBERTY, to participate. Dental Office and applicable Dentists shall automatically be deemed to have accepted participation in a Dental Plan for which they are eligible, and for which they are selected and approved by LIBERTY for participation, unless Dental Office provides written notice to LIBERTY of its desire not to participate in the Dental Plan within thirty (30) days (or such longer period required by applicable law) of being selected and approved by LIBERTY.

"Dentist" means an individual dentist employed by, contracted with, or otherwise engaged by Dental Office to provide dental services. Only those Dentists who have met the credentialing and all other requirements set by LIBERTY, have undergone credentialing by LIBERTY or LIBERTY's designee, and have been approved and activated in the provider network by LIBERTY shall be permitted to perform dental services under this Agreement.

"LIBERTY" means LIBERTY Dental Plan Corporation, or if LIBERTY Dental Plan Corporation is not a party to the applicable contract(s) with the Payor, its subsidiary or affiliate which is the party to the applicable contract(s) with the Payor and/or is licensed or otherwise authorized to operate in the state(s) where Dental Office provides services to Members hereunder.

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

"Payor" means a third-party payor, including, without limitation, a government payor, such as Medicare or Medicaid, for which LIBERTY provides a network and/or performs administrative services.

"Plan Description" means the summary of benefits that applies to a Dental Plan and describes the Covered Services, exclusions, limitations, and Cost Sharing under such Dental Plan. LIBERTY shall provide to Dental Office a copy of the Plan Description(s) for the Dental Plan(s) in which Dental Office and applicable Dentists have been approved by LIBERTY to participate.

"Provider Manual" means the then current version of the applicable provider manual, dental office provider reference manual, or any other manual with a name conveying a similar meaning, along with any other administrative guidelines issued or made available to the Dental Office by LIBERTY. LIBERTY may provide the Provider Manual to Dental Office in paper, CD-ROM, or electronic format or make it available to Dental Office via LIBERTY's website. LIBERTY reserves the right to amend, modify, supplement or remove terms or provisions of the Provider Manual at any time and from time to time.

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 venture 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 of 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 on behalf of Dental Office. LIBERTY shall provide a Form 1099 or other appropriate tax-related documents to Dental Office, 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 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 all Dental Office Agents as applicable, whether or not such restrictions or obligations expressly mention Dental Office Agents. Dental Office shall ensure that all of the Dentists and its other 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 Dentists' and its other Dental Office Agents' acts, omissions, and compliance with the terms of this Agreement.

ARTICLE II
OBLIGATIONS OF DENTAL OFFICE

2.1 Provision of Services.

(a) *Participation in Dental Plan(s).* Dental Office shall participate in the Dental Plan(s) in accordance with this Agreement, including, without limitation, any and all applicable Addendums, Attachments and Schedules to this Agreement, and the corresponding Plan Description(s) and shall provide the appropriate Covered Services to Members who have been assigned to or who have otherwise selected Dental Office. Dental Office acknowledges and agrees that LIBERTY may delete, add to, or otherwise amend or modify the Dental Plans at any time without Dental Office's consent and that such deletions, additions, amendments and modifications shall become immediately effective, subject to any notification requirements under applicable law or this Agreement. If Dental Office or any Dentist becomes ineligible to participate in a particular Dental Plan, Dental Office (and/or the individual Dentist(s), as applicable) shall be de-linked by LIBERTY with respect to such

Dental Plan and Dental Office shall not (and shall ensure the applicable individual Dentist(s) do(es) not) participate under such Dental Plan.

(b) *Standard of Care.* Dental Office shall maintain the dentist/patient relationship with Members and shall be solely responsible for the provision of dental services. Dental Office shall render services in a timely manner and in a manner consistent with all applicable state and/or federal laws and regulations, professionally recognized standards of dental practice, and the professional and ethical standards and guidelines issued by LIBERTY (including any standards or guidelines set forth in the Provider Manual or otherwise issued by LIBERTY). In addition, Dental Office shall conduct its relationship with LIBERTY and Members in a professional and positive manner. Dental Office shall not make untruthful, inaccurate, misrepresentative or disparaging statements or omissions regarding LIBERTY or Members or conduct itself in any fashion that could be detrimental to the business of LIBERTY, as determined by LIBERTY in its sole discretion.

(c) *Availability/Access.* Dental Office shall comply with all availability and access requirements set forth in the Provider Manual, an applicable Addendum or applicable law, whichever provides for the greatest availability/access to Members.

(d) *Posting of Notices.* Dental Office shall post in its office(s) a notice to Members regarding the process for resolving complaints with LIBERTY and/or any other notice required by applicable law or otherwise required by LIBERTY or a Payor.

2.2 Licensure, Credentialing and Compliance.

(a) *Licensure.* Dental Office represents and warrants that it and each Dentist (and each Dental Office Agent, as applicable) has and will maintain without interruption throughout the Term, and any period of Continuation of Care, all licenses, certifications and qualifications required by applicable federal and state laws and regulations to provide services under this Agreement. Dental Office further represents and warrants that neither Dental Office's nor any Dentist's (or Dental Office Agent's, as applicable) required licenses, certifications or qualifications have been suspended, placed on probation, revoked, terminated or otherwise limited or restricted within the past ten (10) years.

(b) *Credentialing.* Dental Office expressly agrees that credentialing approval of the Dental Office by LIBERTY or its designee is a condition precedent to the performance of both Parties under this Agreement. Dental Office shall, and shall ensure Dentists, meet and maintain all credentialing (including federal, state and NCQA guidelines) and other professional qualification requirements of LIBERTY. Dental Office shall ensure that no Dentist performs services under this Agreement unless and until he or she has met the credentialing and all other requirements set by LIBERTY, has undergone credentialing by LIBERTY or LIBERTY's designee, and has been approved and activated on the provider network by LIBERTY. Dental Office shall promptly (no later than two (2) business days) update information it has, or information its Dentists have, on file with LIBERTY with respect to changes that occur outside of the recredentialing cycle, including, but not limited to, changes in office hours, office location openings and closings, changes in dentists at an office, reduction in services, and similar matters.

(c) *Required Notices.* Notwithstanding the generality of the foregoing obligation to update LIBERTY with respect to any changes that occur outside of the recredentialing cycle, Dental Office shall notify LIBERTY immediately upon, and in no event more than two (2) business days following, its discovery of any of the following:

i. Any license, certification, or qualification of Dental Office, a Dentist or other Dental Office Agent that is required under this Agreement is suspended, placed on probation, revoked, terminated, or otherwise limited or restricted;
ii. Dental Office, a Dentist, or other Dental Office Agent becomes the subject of any disciplinary proceeding or action before the applicable state dental board or is otherwise the subject of an investigation by a governmental agency;
iii. Dental Office, a Dentist, or other Dental Office Agent is suspended from, loses eligibility to participate in, or otherwise ceases to participate in a state or federal program;
iv. Dental Office, a Dentist, or other Dental Office Agent is convicted of fraud and/or a felony;
v. Dental Office, a Dentist, or other Dental Office Agent is subject to any determination by any third-party payor, court or other administrative tribunal that Dental Office, a Dentist, or other Dental Office Agent may have or has engaged in the provision of substandard quality of care or abusive billing, fraud, dishonesty or other acts of misconduct in the rendering or reimbursement of Dental Services;
vi. Dental Office or a Dentist is named as a defendant in a malpractice action involving a prior or current Member or there is any malpractice judgment against, or settlement involving, Dental Office or a Dentist;
vii. A lapse in, termination of, or reduction in the amount of insurance coverage required under Section 2.8;

viii. A receiver, liquidator or trustee of Dental Office or a Dentist is appointed by court order, or a petition to liquidate or reorganize is filed against Dental Office or a Dentist under any bankruptcy, reorganization or insolvency law, or Dental Office or a Dentist (1) files a petition in bankruptcy or requests reorganization under any provision of the bankruptcy, reorganization or insolvency laws, (2) makes an assignment for the benefit of its creditors, or (3) is adjudicated bankrupt or insolvent;

ix. There is a change in Dental Office's or a Dentist's business address;

x. There is a change in Dental Office's taxpayer identification number (TIN), name, or ownership; or

xi. There is a change in any information provided on Dental Office's or a Dentist's provider application.

(d) *Compliance.*

i. *Non-Discrimination.* Dental Office shall not, and shall ensure that Dentists and other Dental Office Agents do not, in any way discriminate against Members on the basis of race, color, national origin, ancestry, place of origin or residence, sex, age, religion, sexual orientation, disability, medical condition or health status, marital status, membership in a Dental Plan or program, source of payment, or any other class or status protected by applicable federal and/or state discrimination laws. In addition, Dental Office shall comply with all applicable requirements of 42 U.S.C. Chapter 126 (the Americans with Disabilities Act) and any applicable local requirements concerning adequate space, supplies, sanitation and fire and safety procedures.

ii. *Compliance with Policies and Procedures.* Dental Office shall, and shall ensure all Dentists and other Dental Office Agents, comply fully with, and abide by, the rules, policies, and procedures that LIBERTY has established or will establish, including, but not limited to, those related to timeliness of access to care, coverage rules and payment, quality improvement/management, utilization management (including, but not limited to, precertification procedures, referral processes or protocols, and reporting of clinical encounter data), member grievances, provider credentialing, and LIBERTY's compliance program. Dental Office shall, and shall ensure Dentists and other Dental Office Agents, also comply with all policies, procedures and guidelines identified in the Provider Manual, which may be amended from time to time by LIBERTY.

iii. *Compliance with Applicable Laws.* Dental Office shall, and shall ensure all Dentists and other Dental Office Agents, comply with all applicable state and federal laws, regulations, rules and guidelines.

2.3 Quality Management.

(a) *QMI Program.* LIBERTY shall develop and maintain a Quality Management and Improvement Program ("QMI Program"). Dental Office shall, and shall ensure Dentists, comply with such QMI Program and cooperate with LIBERTY with respect to quality management and improvement activities. In addition, Dental Office acknowledges and agrees that LIBERTY may use the performance data of Dental Office for QMI Program activities.

(b) *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, as required by LIBERTY and applicable laws and regulations, to ensure that such equipment is environmentally safe and technologically accurate. Dental Office shall correct any hazards identified by such inspections or identified at any other time. Dental Office shall maintain equipment maintenance and calibration records and all inspection certificates or reports (collectively, "Equipment Records") for the time periods specified by law or regulations, and in absence of any applicable law or regulation for a period of ten (10) years from the date of the creation of the Equipment Records. The Equipment Records shall be available for review by LIBERTY upon request.

2.4 Administrative Duties.

(a) *Eligibility Verification.* Dental Office shall verify a Member's eligibility to receive Covered Services in accordance with the procedures set forth in the Provider Manual.

(b) *Claim and Other Data Submission.* Claims shall be submitted directly to LIBERTY, except that LIBERTY may designate that claims for services rendered pursuant to certain Dental Plans be submitted directly to a Payor or its designee. Dental Office shall provide to LIBERTY an accurate and detailed description of all Covered Services rendered to Members by completing either an electronic data interchange (EDI) submission in accordance with the Provider Manual or an American Dental

Association (ADA) claim form. Dental Office shall comply with all applicable clean claims requirements, in accordance with applicable law and regulation and as set forth in the Provider Manual. Dental Office's failure to submit a Clean Claim, subject to the claim correction and resubmission procedures set forth in the Provider Manual and applicable law, forfeits Dental Office's right to payment on that claim unless the failure was the result of a catastrophic event, as determined by LIBERTY, that substantially interfered with the Dental Office's normal business operations.

(c) *Cooperation with LIBERTY Procedures.* Dental Office shall cooperate with LIBERTY, and participate at LIBERTY's direction, in service standards, quality management, peer review and audit systems, on-site inspections and grievance procedures, as may be further set forth in the Provider Manual, and shall comply with all final determinations rendered by the peer review process or grievance procedures established by LIBERTY. Additionally, Dental Office must, in good faith, cooperate with LIBERTY in the performance or provision of administrative services or functions by LIBERTY, and make information available, in a timely matter, as reasonably requested by LIBERTY to enable it to perform such functions.

2.5 Confidentiality.

(a) *Member Information.* Dental Office shall safeguard Members' privacy and confidentiality, ensure 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, and 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 of 1996 and the regulations promulgated thereunder (collectively, "HIPAA"), as well as the Health Information Technology for Economic and Clinical Health Act and the 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) *Dental Office Information*. Dental Office agrees that a Payor and LIBERTY may share with each other, or with their designated authorized agents, Dental Office information collected by either Payor or LIBERTY pertaining to, without limitation: (i) quality assurance and improvement; (ii) utilization management, including reporting of clinical encounter data; (iii) patient satisfaction; (iv) credentialing; (v) maintenance of medical and dental records, record audits and inspection; (vi) health education; (vii) case management; (viii) disease management; and (ix) peer review.

(c) *Other Confidential Information.* Dental Office acknowledges that, by reason of Dental Office's performance of services under this Agreement, Dental Office, Dentists, and other Dental Office Agents may have access to confidential and/or proprietary information of LIBERTY or of other third parties to which LIBERTY has confidentiality obligations ("Third Parties"). This confidential and/or proprietary information may include, 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 and provider lists, identifying information regarding Members, and relationships and agreements between LIBERTY (or Third Parties) 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 Third Parties to which such Confidential Information belongs, and Dental Office shall, and shall ensure Dentists and other Dental Office Agents, keep all Confidential Information in strictest confidence and use Confidential Information for no other purpose than, and only to the extent necessary, to carry out Dental Office's obligations under this Agreement and not disclose any Confidential Information to any third party without the prior written authorization of LIBERTY.

i. *Exceptions; Required Disclosures.* The obligation of confidentiality imposed by this Section 2.5(c) shall not apply to information that is, or becomes, publicly known and generally available to the public through no act or omission of Dental Office (or any of its Dentists or Dental Office Agents) 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 requested 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.

ii. *Return of Confidential Information.* Upon termination or expiration of the Agreement, Dental Office shall return all Confidential Information (except any 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 Confidential Information.

2.6 Inspection, Evaluation, Audit; Document Retention.

(a) *Access to Records.* Dental Office shall permit LIBERTY, upon advance written notice, 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 Members, 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, or as otherwise requested by LIBERTY from time to time. Dental Office shall notify LIBERTY of any disclosure of Records it is required to make to a governmental agency or division. Dental Office may not make the access or the provision of Records described in this Section 2.6(a) 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 2.6(b) below.

(b) *Retention Period.* Dental Office shall maintain the Records for ten (10) years from the termination or expiration of the Agreement or the completion date of any audit conducted pursuant to Section 2.6(a) (whichever is later), unless otherwise required by law.

2.7 Hold Harmless. Dental Office agrees that in no event, including, but not limited to, non-payment by LIBERTY or Payor, insolvency of LIBERTY or Payor, or breach of this Agreement, shall Dental Office bill, collect a deposit from, impose surcharges on, 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, and has acknowledged in writing, 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 or Payor, and shall supersede any oral or written agreement between Dental Office and Member.

2.8 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 Office Agent 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.

2.9 Indemnification. LIBERTY shall not be liable for any act or omission by Dental Office, or by any Dentist or other Dental Office Agent, in connection with, or in any way arising out of, the performance or nonperformance of any services by Dental Office, Dentists, or Dental Office Agents ("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 (including, but not limited to, compensatory, consequential and punitive damages), obligations, liabilities, awards and expenses (including, without limitation: defense costs, reasonable attorney's fees, court costs, 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 Dentist's or Dental Office Agent's) breach of this Agreement; or (iii) any representations, warranties,

covenants, agreements, obligations, or acknowledgments of Dental Office, a Dentist, or a Dental Office Agent, as set forth in this Agreement (including, but not limited to, any provider application form).

ARTICLE III
COMPENSATION

3.1 Fees. In exchange for the provision of Covered Services to Members, Dental Office shall be compensated in accordance with the applicable compensation set forth in an Exhibit and/or in the applicable compensation addendum or fee schedule based upon the applicable coverage of the Dental Plan(s) in which Dental Office participates. LIBERTY shall pay or deny Dental Office claims in accordance with any applicable prompt payment statutes. Dental Office acknowledges and agrees that all such compensation will be based on the current, applicable Dental Plan(s). Dental Office agrees to accept such compensation and any applicable Cost Sharing as payment in full for the rendered Covered Services. Dental Office acknowledges that LIBERTY shall not be liable in any way for payment for Covered Services rendered by Dental Office to Members to the extent such payment is the responsibility of the Payor under the applicable Dental Plan. In addition, LIBERTY shall not directly or indirectly make payment to a Dental Office as an inducement to reduce or limit medically necessary services furnished to a Member.

3.2 Offsets and Deductions. LIBERTY may offset and deduct from any amounts due to Dental Office any amounts owed by Dental Office, including, but not limited to: (i) any overpayment or error in payment made to Dental Office by LIBERTY, and (ii) any amounts necessary to resolve a Member complaint or grievance, as determined by LIBERTY's Dental Director or designee. Any offsets and/or deductions shall be made by LIBERTY in accordance with applicable laws and/or LIBERTY'S policies and procedures.

3.3 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 services and cooperate with respect to any subrogation claim LIBERTY may pursue.

ARTICLE IV
TERM AND TERMINATION

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

4.2 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 or an individual Dentist from further Member selection if LIBERTY determines that it needs to do so to investigate or manage Dental Office compliance (or with respect to an individual Dentist, such Dentist's compliance) with Agreement terms, though LIBERTY is not obligated to do so. LIBERTY may also terminate this Agreement as follows:

i. *Immediate Termination by LIBERTY.* 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) Dental Office's loss of, or failure to maintain, general and/or professional liability insurance as required under this Agreement, (ii) Dental Office's exclusion from participation in Medicare, Medicaid, or any other third-party, state or federal program, (iii) felony conviction of Dental Office, (iv) impairment of Dental Office's ability to provide services or Dental Office's refusal to see and/or treat Members, (v) fraud by Dental Office, (vi) Dental Office's failure or inability at any time to satisfy LIBERTY's then current credentialing criteria, (vii) Dental Office's failure to comply with Subsection 2.2(c) hereof, or (viii) Dental Office breaches Section 5.1 below. LIBERTY also has the right

to terminate the Agreement with respect to the participation of only a particular Dentist or Dentists of Dental Office if LIBERTY determines, in its sole discretion, that any of the foregoing events have occurred with respect to such Dentist(s).

ii. *Termination by LIBERTY Upon Dental Office Breach.* LIBERTY may also terminate this Agreement upon thirty (30) days' written notice to Dental Office if LIBERTY has determined that Dental Office is in breach of any material provision of this Agreement; provided, however, that if such breach constitutes a terminable event under Section 4.2(c)(i) above, LIBERTY may immediately terminate Dental Office pursuant to such Section. If such breach is cured to LIBERTY's satisfaction 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 thirty-day (30-day) cure period, LIBERTY may immediately terminate the Agreement.

(d) *Automatic Termination.* This Agreement shall automatically terminate upon: (i) LIBERTY's determination, in its sole discretion, that any license, certification, or qualification of Dental Office, Dentist, or Dental Agent that is required under this Agreement is suspended, placed on probation, revoked, terminated, or otherwise limited or restricted, (ii) the institution by or against Dental Office of insolvency, receivership or bankruptcy proceedings, or any other proceedings for the settlement of Dental Office's debts, (iii) Dental Office making an assignment for the benefit of creditors, or (iv) Dental Office's dissolution or ceasing to do business. In the event an individual office location of Dental Office activated under this Agreement ceases to do business, the Agreement shall automatically terminate with respect to such office location. In addition, this Agreement shall terminate with respect to an individual Dentist in the event of such Dentist's death (or, where Dental Office has a single Dentist, the Agreement shall terminate in its entirety in the event of such Dentist's death).

4.3 Effect of Termination.

(a) *Prior and Continuing Obligations.* Notwithstanding any other provision in this Agreement, 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) *Continuation of Care.* In the event of the termination of this Agreement, and unless prohibited by applicable law, Dental Office shall complete all services started prior to the effective date of termination, consistent with professionally recognized standards of dental practice and LIBERTY's Provider Manual, and as otherwise required by applicable law or regulation.

(c) *Records.* In the event of termination of this Agreement, Dental Office shall, 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 (or such lesser time period required by applicable law) 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 shall notify Members regarding provider termination prior to the termination date. For services started prior to the termination date, Dental Office agrees to charge the Member no more for services than would have been payable by the Member had this Agreement not terminated.

ARTICLE V
GENERAL PROVISIONS

5.1 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.

5.2 Dentist-Patient Communications. Dental Office may freely communicate with Members regarding such Members' dental treatment (regardless of benefit coverage limitations), and 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 Covered 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 Covered Services under LIBERTY's Dental Plans.

5.3 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 5.3 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 the 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 QMI Program.

5.4 Addendum Conflict. Each state-specific or product-specific addendum is expressly incorporated into this Agreement and is binding upon the Parties. In the event of any inconsistent or contrary language between any state-specific or product-specific addendum and any part of this Agreement, the Parties agree that the provisions of any state-specific or product-specific addendum shall prevail as applicable to the Covered Services provided to Members of a specific product, issued in a specific state, unless otherwise required by applicable law.

5.5 Miscellaneous.

(a) *Applicable Law.* This Agreement and the rights and obligations of the Parties 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 under this Agreement shall operate as a waiver thereof, nor will any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any other right, power, or privilege under this Agreement. 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, the applicable Provider Manual, and all applicable attachments, exhibits, addenda and fee schedules, all of which are incorporated herein by reference) 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 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 even if LIBERTY fails to notify Dental Office of the modification. In addition, LIBERTY may remove, amend, modify or supplement any term or provision of this Agreement (including attachments, exhibits, addenda and fee schedules) upon written notice to Dental Office; if Dental Office fails to object to such modification in writing within ten (10) calendar days of such notification (or such longer notice period if required by applicable law), 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 all 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 1.2, 2.4(b)-(c), 2.5, 2.6, 2.7, 2.9, 4.3, 5.1, 5.2, 5.4.

(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/Signatures. This Agreement may not be executed in counterparts. Any signature delivered or received via facsimile or as an electronic image (e.g., PDF format) shall be deemed to be an original signature hereto.

(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, (iii) mailed by a commercial overnight courier that provides receipt of delivery; or (iv) in the event that notice is being made to Dental Office by LIBERTY, mailed via regular U.S. mail, delivered via facsimile (fax), delivered via electronic mail (email), or delivered via any method described in (i)-(iii). 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, fax and/or email specified on signature page

[THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.]

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

("DENTAL OFFICE"):	**LIBERTY Dental Plan Corporation:**
Authorized Signature	Signature
Print Name of Signatory	Print Name of Signatory
Title	Title
Date	***Effective 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)	

MEDICARE ADVANTAGE PROGRAM REQUIREMENTS ADDENDUM

THIS MEDICARE ADVANTAGE ("MA") PROGRAM REQUIREMENTS ADDENDUM (the "Addendum") is made and entered into by and between **LIBERTY Dental Plan Corporation** (collectively with any affiliates, subsidiaries and parent corporations, and as defined in the Agreement, "LIBERTY") and [LEGAL NAME OF DENTAL OFFICE] _____ ("Dental Office") and supplements the Provider Agreement entered into by LIBERTY and Dental Office. This Addendum shall become effective as of the date specified by LIBERTY below.

I. Definitions. For purposes of this Addendum the following terms shall have the meanings set out below:

(1) "**Downstream Entity**" means any party that enters into a written arrangement, acceptable to Centers for Medicare and Medicaid Services ("CMS"), with persons or entities involved with the MA benefit, below the level of the arrangement between a health plan that operates a Medicare Part C program ("MA Plan") and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Dental Office is a Downstream Entity of LIBERTY.

(2) "**Dual Eligible Member**" means a Member who is entitled to medical assistance under Medicare and Medicaid.

(3) "**First Tier Entity**" means any party that enters into a written arrangement, acceptable to CMS, with an MA Plan to provide administrative services or health care services for a Member. LIBERTY is a First Tier Entity for various MA Plans.

(4) "**LIBERTY**" means LIBERTY Dental Plan Corporation or, if LIBERTY Dental Plan Corporation is not a party to the applicable contract(s) with the MA Plan, its subsidiary or affiliate that is the party to the applicable contract(s) with the MA Plan and/or is licensed or otherwise authorized to operate in the state(s) where Dental Office provides services under this Addendum.

(5) "**Medicare Advantage**" or "**MA**" means an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

(6) "**Member**" means a Medicare Advantage eligible individual who has enrolled in or elected coverage through an MA Plan.

II. MA Provider Enrollment Requirement. Dental Office shall, and shall cause its employed and subcontracted providers to be enrolled as a practitioner in Medicare in an approved status while participating in LIBERTY's dental network(s), and in order to provide or seek reimbursement for services rendered to MA members under the Agreement or Addenda, except as otherwise permitted by applicable law. Notwithstanding the foregoing, while Dental Office is in a Medicare opt out status ("Opted Out"), Dental Office shall not provide or seek (and shall prohibit any Opted Out providers it employs or subcontracts from providing or seeking) reimbursement for non-emergent services rendered to MA members under the Agreement or Addenda, except as otherwise permitted by applicable law.

III. MA Obligations and Requirements. CMS requires that specific terms and conditions be incorporated into agreements between an MA Plan and a First Tier Entity, and a First Tier Entity and any Downstream Entity, to comply with the Medicare laws, regulations and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066. As a Downstream Entity of

LIBERTY, Dental Office shall comply with the following terms and conditions as they pertain to services rendered to Members:

A. Audits; Access to Records and Records Retention. Dental Office shall permit, and shall cause its contractors and subcontractors to permit, LIBERTY, MA Plan, the Department of Health and Human Services (HHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS and/or their designees to audit, evaluate, collect and inspect any books, contracts (including, but not limited to, any agreements between Dental Office and its employees, contractors and/or subcontractors providing services related to services provided to Members), computers or other electronic systems, documents, papers, medical records, patient care documentation and other records and information involved or in connection with the provision of services related to MA Plan's contract with CMS (collectively, "Books and Records"). Dental Office shall maintain, and shall cause its contractors and subcontractors to maintain, all Books and Records in an accurate and timely manner. Dental Office shall make available, and shall cause its contractors and subcontractors to make available, all Books and Records for such inspection, evaluation or audit during the Term of this Agreement and for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of the Provider Agreement occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency's designee (i) determines there is a special need to retain records for a longer period of time; (ii) there has been a termination, dispute or allegation of fraud or similar fault by MA Plan, LIBERTY or Dental Office, in which case the retention period may be extended to six (6) years from the date of final resolution of the termination, dispute, or similar fault; (iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time.

B. Provision of Books and Records. Dental Office shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Dental Office (a) to provide any of the above-referenced individuals or entities with timely access to records, information and data necessary for (1) MA Plan to meet its obligations under its contract with CMS and/or (2) CMS to administer and evaluate the MA program; and (b) to submit all reports and clinical information required by MA Plan under its contract with CMS. In pursuance thereof, Dental Office shall provide to LIBERTY applicable information and/or Books and Records as may be reasonably requested by MA Plan in connection with services rendered to Members.

C. Privacy and Accuracy of Records. Dental Office shall comply with all applicable state and federal laws, rules and regulations, Medicare program requirements, the requirements in the MA Plan's contract with CMS, and MA Plan requirements regarding privacy, security, confidentiality, accuracy and disclosure of records (including, but not limited to, medical records, personally identifiable information and/or protected health information and enrollment information), including, without limitation, (i) the federal Health Insurance Portability and Accountability Act of 1996 and the rules and regulations promulgated thereunder (collectively, "HIPAA"), (ii) 42 C.F.R. § 422.504(a)(13), (iii) 42 C.F.R. § 422.118, and (iv) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Dental Office shall release such information only (a) in accordance with applicable state and/or federal law, or (b) pursuant to a valid court order or subpoena consistent with state and federal law.

D. Hold Members Harmless. Dental Office shall not hold a Member liable for the payment of any fees that are the legal obligation of an MA Plan and/or LIBERTY. For example, a Member shall not incur any liability in the event the applicable MA Plan and/or LIBERTY becomes insolvent or suffers other financial difficulties or in the event of a contract breach or an issue with Dental Office billing.

E. Hold Dual Eligible Members Harmless. With respect to those Members who are Dual Eligible Members, Dental Office acknowledges and agrees that it shall not hold such Dual Eligible Members liable for Medicare Part A and Part B cost-sharing when a state is responsible for paying such amounts. Dental Office shall accept MA Plan's and/or LIBERTY's payment as payment in full or bill the appropriate state source if MA Plan has not assumed such state's financial responsibility under an agreement between MA Plan and such state. Dental Office shall not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Medicaid if the individual were not enrolled in such plan. LIBERTY shall inform Dental Office of Medicare and Medicaid benefits and rules for Members who are Dual Eligible Members.

F. MA Plan's Contractual Obligations. All services provided to Members by Dental Office, or other activities performed by Dental Office for Members, shall be consistent with and comply with the requirements of the MA Plan's contract with CMS.

G. Prompt Payment of Claims. LIBERTY will process and pay or deny claims for services provided by Dental Office in accordance with the Provider Agreement and any and all applicable laws, including, but not limited to, any and all applicable prompt payment laws.

H. Delegation. Dental Office acknowledges and agrees that if the MA Plan delegates the selection of providers, contractors or subcontractors to another organization, including LIBERTY, the MA Plan retains the right to approve, suspend or terminate any such arrangement.

I. Compliance with MA Plan's Policies and Procedures. Dental Office shall comply with all policies and procedures of MA Plan to the extent applicable. Such policies include, without limitation, written standards for the following: (i) timeliness of access to care and member services; (ii) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); (iii) Dental Office consideration of Member input into Dental Office's proposed treatment plan; (iv) MA Plan's accreditation standards; and (v) MA Plan's compliance program, which encourages effective communication between Dental Office and MA Plan's Compliance Officer and participation by Dental Office in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. The aforementioned policies and procedures are identified in MA Plan's Provider Manual, which is incorporated herein by reference and may be amended from time to time by MA Plan.

J. Delegation (Accountability) Provisions. In the event Dental Office is delegated any of an MA Plan's activities or responsibilities under its contract with CMS as a subcontractor or delegate of LIBERTY, the following requirements apply:

(1) Delegated Activities and Reporting. All delegated activities and reporting responsibilities thereto are set forth in the Provider Agreement.

(2) Revocation. In the event CMS or MA Plan determines that Dental Office does not satisfactorily perform the delegated activities or any plan of correction or does not timely perform the requisite reporting or disclosure requirements, any and all of the delegated activities or reporting requirements may be revoked upon notice by CMS or the MA Plan to Dental Office and/or LIBERTY.

(3) Monitoring. Any delegated activities will be monitored by the MA Plan on an ongoing basis. Dental Office shall participate cooperatively with all monitoring by the MA Plan.

(4) Credentialing. The credentials of medical professionals affiliated with Dental Office and/or LIBERTY will be reviewed by MA Plan, or Dental Office's and/or LIBERTY's credentialing process will be reviewed and approved by MA Plan and MA Plan will audit the credentialing process on an ongoing basis.

(5) No Assignment of Responsibility. Dental Office understands that Dental Office may not delegate, transfer or assign any of Dental Office's or LIBERTY's obligations with respect to Members without MA Plan's and/or LIBERTY's prior written consent.

(6) Compliance with Laws and Regulations. Dental Office shall comply, and shall require any and all of its employees, contractors and subcontractors to comply, with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and all other applicable state and federal laws, rules and regulations, as may be amended from time to time, including, without limitation, (i) laws, rules and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act, and the anti-kickback statute; (ii) applicable state laws regarding patients' advance directives as defined in the Patient Self-Determination Act, as may be amended from time to time; (iii) HIPAA administrative simplification rules; and (iv) laws, rules and regulations and CMS instructions and guidelines regarding marketing. Additionally, Dental Office shall maintain full participation status in the federal

Medicare program and shall ensure that it and none of its employees, contractors, or subcontractors are or have been excluded, debarred, suspended or are otherwise ineligible to participate in the federal health care programs or in federal procurement or non-procurement programs nor are included on the list of sanctioned individuals maintained by (a) the U.S. Department of Health and Human Services' Office of Inspector General, (b) the System Administration Management, and (c) any state agency where Dental Office provides services. If Dental Office or any of its employees or subcontractors is sanctioned or added to one of these three lists, Dental Office must notify LIBERTY within five (5) days of discovery.

K. Accountability. Dental Office hereby acknowledges and agrees that MA Plan oversees the provision of services by Dental Office to Members and that MA Plan shall be accountable to CMS for any functions and responsibilities described in the MA regulations.

L. Benefit Continuation. Upon termination of Dental Office's status as a participating provider by LIBERTY or an MA Plan (unless such termination was related to safety or other concerns), Dental Office shall continue to provide health care benefits/services to Members in a manner that ensures medically appropriate continuity of care for the time period required by applicable law.

M. Physician Incentive Plans. The parties agree (i) that no payments made to Dental Office are financial incentives or inducements to reduce, limit or withhold medically necessary services to Members; and (ii) that any incentive plans applicable to Dental Office are and shall be in compliance with applicable state and federal laws, rules and regulations and in accordance with MA Plan's contract with CMS. Upon request and as applicable, Dental Office shall disclose, and shall permit LIBERTY to disclose, to an MA Plan the terms and conditions of any "physician incentive plan" as defined by CMS and/or any state or federal law, rule or regulation.

III. Conflict. Except as provided herein, all provisions of the Provider Agreement not inconsistent with the provisions of this Addendum shall remain in full force and effect. The provisions of this Addendum shall supersede and replace any inconsistent provisions to such Provider Agreement to ensure compliance with required CMS provisions, and shall continue concurrently with the term of the Provider Agreement.

Agreed and accepted by:

[DENTAL OFFICE]:	**LIBERTY Dental Plan Corporation:**
Authorized Signature	Signature
Print Name of Signatory	Print Name of Signatory
Title	Title
Date	***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. Illinois Contract Requirements.

    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")

Authorized Signature

Print Name

Title

Date

Individual Medicaid Number

Group Medicaid Number (if applicable)

LIBERTY Dental Plan Corporation ("LIBERTY"):

Signature

Print Name

Title

Effective Date

Form **W-9**
(Rev. December 2014)
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.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally 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 instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

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); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 3.

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

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

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, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

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 – 5** (including SSN on page 3)
- **Page 7**
- **Pages 9 – 10**
- **Page 13**
- **Page 16** (Work History for Past 5 Years – must include month/year)
- **Pages 19 – 22**
- **Page 23** (Bottom Half)
- **Page 25** (Tax ID Info)
- **Pages 26 – 27** (Only complete if you have additional locations)
- **Forms A and/or B**

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)

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

State: _____ CS License #: _____ Expiration Date: _____ (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: _____ 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

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 ☐ Judgment ☐ Arbitration ☐ Other
☐ Settlement out of Court ☐ Pending ☐ Mediation

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:** _____

Electronic Fund Transfer (EFT) Form

(Please Print Clearly)

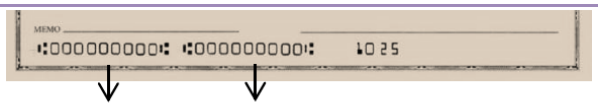
FACILITY INFORMATION

Type of Authorization: ☐ Add ☐ Update ☐ Cancel

Facility Name:	**Facility ID:**	**Tax ID:**
Facility Address:		
Email Address:		
UPDATED EMAIL ADDRESS:		

ACCOUNT INFORMATION

Account Legal Name:	**Account Number:**
Account Type: ☐ **Checking** ☐ **Savings**	Bank Routing Number:
Name of Financial Institution:	



Routing Number Account Number

One of the following must be attached:

☐ Voided Check

☐ Confirmation letter from your bank with required account information

AUTHORIZATION

Please note that all references to "me," "my" or "I" below refer to the dental office contracted with LIBERTY Dental Plan and to which payments shall be directly deposited by LIBERTY Dental Plan under this authorization form.

By signing below, I hereby authorize LIBERTY Dental Plan to deposit any amounts due to me, less any mandatory or authorized withholdings or deductions, into the account indicated on this form. I understand that my payment statements will be available online and that paper statements will no longer be provided to me.

If at any time the amount so deposited exceeds the amount actually due and payable to me, I hereby authorize LIBERTY Dental Plan to either: (i) withhold a sum equal to the overpayment from future amounts due to me; or (ii) recover such overpayment from the above-indicated account. I understand that it is my responsibility to verify that payments have been credited to my account and I agree that LIBERTY Dental Plan assumes no liability for overdrafts for any reason whatsoever. I further understand that in the event my financial institution is not able to deposit any electronic transfer into my account due to any action or inaction by me, LIBERTY Dental Plan cannot issue the funds to me until the funds are returned to LIBERTY Dental Plan by the financial institution.

I certify that the account is drawn in my name and that I have sole control of the account. I certify that the account is drawn in the legal business name of the dental office and that such dental office has sole control of the account. Either way, I certify that all arrangements between my financial institution(s) and me are in accordance with all applicable federal and state laws and regulations.

This authorization will remain in effect until I have submitted a new Electronic Fund Transfer Form to LIBERTY Dental Plan or until either Dental Plan or I have provided the other with written notice to terminate this authorization or direct deposit arrangement. I understand that I can change my account information or financial institution arrangement by completing a new Electronic Fund Transfer Form available from LIBERTY Dental Plan. I agree to immediately notify LIBERTY Dental Plan before I close any account listed above while this authorization is in effect.

☐ I certify that 100% of the net deposit will not be sent to a financial institution outside the jurisdiction of the United States.

Authorized Signature:	Date:
Print Name:	Title:

CANCELLATION

I hereby cancel my Electronic Fund Transfer Authorization.	
Authorized Signature:	Date:
Print Name:	Title:

LIBERTY DENTAL PLAN USE ONLY

Vendor Name:	Vendor ID:

Electronic Fund Transfer (EFT) Form

(Please Print Clearly)

Instructions for Completing the Electronic Fund Transfer (EFT) Form

Please allow 30 days after submission of form to receive your first Electronic Fund Transfer (EFT) deposit. Forms that are illegible or not fully or accurately completed will result in delays in processing the EFT deposit arrangement.

General Instructions
Complete all portions of the form according to the type of enrollment and sign where required.

Facility Information – Clearly print and complete all parts of this section for any addition, update or cancellation to account. Enter your current email address for verification purposes in the "Email Address" section.

Update to Email Address – Clearly print the email address you wish to update the account to in the "Updated Email Address" section. (A **voided check or bank letter will not be required** for submission if this is the only change to the account information.)

Account Information - Attach a voided check or Confirmation Letter from your bank for the account listed. Please note that this EFT Form will not be processed unless the voided check or bank letter is attached.

Authorization – An authorized signature is required for any addition, change or update to an account. The signer's name must be clearly printed under the signature, title provided, and form dated. Omission will result in delays in processing this EFT form. The certification box above the signature must be checked when adding or changing bank account information.

Cancellation - An authorized signature is required for cancellation of the EFT deposit arrangement. The signer's name must be clearly printed under the signature, title provided, and form dated. Omissions will result in delays in processing of the EFT form.

Please return the completed EFT form along with all required documents by email or regular mail.

Email submissions to: **prinquiries@libertydentalplan.com**

Mail submissions to:

Attn. Professional Relations
LIBERTY Dental Plan
P.O. Box 26110
Santa Ana, CA 92799

LIBERTY Provider Compliance Attestation

I certify that I am an authorized representative of the Provider named below, for all locations listed below, and confirm the following representations are true, based upon current information and reasonable belief:

1. **CMS Compliance & FWA Training.** Provider complies with all Centers for Medicare and Medicaid Services (CMS) General Compliance and Fraud Waste and Abuse (FWA) training requirements, including ensuring that all Provider employees and other personnel who support LIBERTY business, including LIBERTY's Plan Partners' Medicare Advantage, Medicare-Medicaid (Duals), and/or Medicaid business ("LIBERTY Government Business") receive both General Compliance and FWA training within 90 days of hire, and annually thereafter, utilizing one or more of the following methods:

    - General Compliance and FWA training is completed using the web-based modules located on the CMS Medicare Learning Network (MLN) at:

        https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf

        https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf

    and/or

    - Provider distributes LIBERTY's FWA Training (available at www.libertydentalplan.com) to all Provider employees and other personnel who support LIBERTY Government Business, within 90 days of hire and annually thereafter.

2. **Code of Conduct.** Provider distributes a Code of Conduct (LIBERTY's or Provider's own Code of Conduct, if comparable to LIBERTY's)* to all Provider employees and other personnel who support LIBERTY Government Business, within 90 days of hire and annually thereafter.

    - Provider distributes LIBERTY's Code of Conduct located at www.libertydentalplan.com

    and/or

    - Provider distributes its own Code of Conduct, which is comparable to LIBERTY's.

3. **Cultural Competency & Critical Incident Training.** Provider ensures all Provider employees and other personnel who support LIBERTY's Government Business complete LIBERTY's Cultural Competency & Critical Incident trainings within 90 days of hire and annually thereafter. To access the training, visit www.libertydentalplan.com and select Providers.

4. **Record Retention.** Provider maintains supporting documentation for a period of ten (10) years after training completion, and Code of Conduct dissemination, for all Provider employees and other personnel supporting LIBERTY Government Business, and can furnish the documentation upon request.

**Note: LIBERTY is required to communicate, through dissemination of LIBERTY's Code of Conduct, its commitment to conducting business in an ethical manner, and consistent with governing law and program requirements. LIBERTY will also accept the dissemination of Provider's comparable Code of Conduct to fulfill this requirement.*

LIBERTY Provider Compliance Attestation

*Office Locations:

Office ID	Office Name	Address

**For multiple locations, please attach a list of all applicable Dental Office Names and Addresses.*

Provider Name (Owner Dentist)

To be completed by Provider (or authorized representative):

Print Name

Title

Signature

Date

LIBERTY Dental Plan

PROVIDER AUTHORIZED SIGNATORY FORM

"Dental Office": _____
Dental Office Name

_____
Dental Office Address - if these signatories are authorized for multiple locations, please attach a list of all applicable Dental Office Names and Addresses

By signing this Provider Authorized Signatory Form, Dental Office represents and warrants that the individuals listed below are Authorized Signatories, as defined herein. "Authorized Signatories" are those individuals who are authorized by Dental Office to approve, sign and execute, acknowledge, and deliver, in the name and on behalf of Dental Office, any and all contracts, including but not limited to: provider agreements, addenda, fee schedules, amendments, letters of intent, letters of agreement, memoranda of understanding, applications, attestations, settlements, releases, waivers, renewals, and all other forms, documents, and agreements (collectively, "Contracts"). Dental Office represents and warrants that all Authorized Signatories are authorized to bind Dental Office to all such Contracts.

AUTHORIZED SIGNATORIES	
Name	**Title**

Dental Office acknowledges and agrees that LIBERTY Dental Plan ("LIBERTY") is not required to accept all Authorized Signatories and further acknowledges and agrees that some Contracts (such as credentialing applications, DEA Waiver Request forms, etc.) may require a dentist or other specific signature. In the event of any changes to its Authorized Signatories, Dental Office shall immediately notify LIBERTY of such changes in writing and shall complete a new Provider Authorized Signatory Form.

LIBERTY Dental Plan
Attention: Professional Relations
340 Commerce, Suite 100
Irvine, CA 92602
prnational@libertydentalplan.com

Acknowledged and agreed:

Note: If the dental practice is not incorporated, the dentist/owner must sign.
If the dental practice is incorporated, the President, CEO, or Chairman must sign.

_____
Authorized Signature

_____
Print Name

_____
Title

_____
Date