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.

LIBERTY DENTAL PLAN | PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT (the "Agreement") is made and entered into by and between **LIBERTY Dental Plan of New Jersey, Inc.** ("LIBERTY"), a subsidiary of LIBERTY Dental Plan Corporation, and the legal entity or individual qualified and licensed to practice dentistry in the state of New Jersey [LEGAL NAME OF DENTAL OFFICE]: _____ ("Dental Office"), a [CHECK ONE]: □ *individual practice* □ *partnership* □ *professional corporation* □ *other*: _____, effective as of the date specified by LIBERTY on the signature page (the "Effective Date"). LIBERTY and Dental Office may each be referred to as a "Party" and together, may be referred to as the "Parties."

RECITALS

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

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

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

DEFINITIONS

"Agents" 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.

"Clean Claim" means a claim for a service or supply covered by the Dental Plan which is (i) submitted with all the information requested by LIBERTY on the claim form or in other instructions distributed to the provider or covered person on the date of service, (ii) does not require special treatment (i.e., unusual claim processing is required to determine whether a service or supply is covered, including experimental treatments or newly approved medications), and (iii) is not reasonably believed by LIBERTY to have been submitted fraudulently.

"Continuity of Care" means the obligation of LIBERTY to continue to reimburse a provider for services, which would have been Covered Services had the Agreement not been terminated, provided to a Member beyond the termination date where certain "Special Circumstances," as defined below, are present.

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

"Covered Services" means medically necessary and appropriate dental benefits, services, treatment and supplies provided to a Member under the applicable Dental Plan, as set forth in the Plan Description, for which LIBERTY is obligated to pay benefits.

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

"Dental Office" means the individual dentist or dental practice (whether a partnership, professional corporation or other business entity) named in the above preamble and on the signature page of this Agreement. As further described in Section 1.1 ("Agents"), "Dental Office" shall be construed to include, with respect to all restrictions

upon and obligations of Dental Office under this Agreement, all dentists of Dental Office performing services under this Agreement. Only those dentists who are at Dental Office locations approved by LIBERTY and 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 on the provider network by LIBERTY shall be permitted to perform services under this Agreement.

"Dental Plan(s)" means the applicable dental benefits plan outlining terms of coverage provided by LIBERTY, in which plan Dental Office and its dentists are eligible, and selected and approved by LIBERTY, to participate.
"Emergency" means procedures to evaluate and stabilize dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infections that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

"Member" means an individual enrolled in the Dental Plan(s) whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the dental plan, or in the case of an individual contract, the person in whose name the contract is issued.

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

"Special Circumstances" means a condition in which it is medically necessary for the covered person to continue treatment with the treating provider or where the treating provider reasonably believes that discontinuing care by the provider could cause harm to a Member who has a special circumstance, including a Member with a disability, acute condition, life threatening illness, who is receiving post-operative care, or who is past the twenty-forth (24th) week of pregnancy.

"Specialist" means a dentist whose training and expertise are in a specific area of dentistry. Recognized clinical specialists in dentistry include, but are not limited to, endodontists, oral and maxillofacial surgeons, oral pathologists, orthodontists, periodontists and prosthodontists.

"Utilization Review" means the review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a Member, whether undertaken prior to, concurrent with or subsequent to the delivery of such services, are medically necessary.

ARTICLE I: RELATIONSHIP OF THE PARTIES

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

ARTICLE II: OBLIGATIONS OF DENTAL OFFICE

2.1 Provision of Services. Dental Office agrees to:

(a) Participate in the Dental Plan(s), as provided by LIBERTY and in accordance with applicable fee schedules, and provide the applicable Covered Services to all Members selecting Dental Office. Dental Office acknowledges and agrees that LIBERTY may delete, add to, or otherwise amend or modify the Dental Plans, and that such deletions, additions, amendments and modifications will be deemed agreed to by Dental Office and shall become part of this Agreement. Where Dental Office has not been provided a list of Covered Services and/or Dental Office is uncertain as to whether a particular service is a Covered Service, Dental Office shall make reasonable efforts to contact LIBERTY (as designee for the applicable

managed care organization) and obtain a coverage determination prior to advising a Member as to coverage and liability for payment and prior to providing the service.

(b) Render services in a timely manner consistent with the professional and ethical standards of the American Dental Association ("ADA") and of LIBERTY (including LIBERTY's Dental Director), which services shall be the best possible in light of the technology and medical knowledge which is available at the present time. Dental Office must maintain at least thirty (30) regularly scheduled office hours per week in which Dental Office is available for the treatment of Members. Dental Office shall provide treatment to a Member for an Emergency within twenty-four (24) hours of the Emergency.

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

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

2.2 Appointments; Non-discrimination. Dental Office agrees to render all necessary dental services to each Member during Dental Office's regular office hours, subject to prior appointments. Within ten (10) working days of a request by a Member for an appointment, Dental Office shall grant an appointment to such Member. Dental Office shall not discriminate in the treatment of Members or in the quality of services delivered to Members on the basis of race, sex, affectional or sexual orientation, age, religion, marital status, place of residence, health status, membership in a Dental Plan or program, national origin, disability, type of illness or condition, or source of payment.

2.3 Administrative Duties. Dental Office agrees to comply fully with, and abide by, the rules, policies and procedures that LIBERTY (a) has established or will establish to meet general or specific obligations placed on LIBERTY by statute, regulation, or New Jersey Department of Banking and Insurance (DOBI) guidelines, bulletins or policies and (b) has provided to the Dental Office at least thirty (30) days in advance of implementation (unless such advance notice is not possible due to LIBERTY's receipt of shorter notice from the applicable governmental agency, in which case LIBERTY shall provide Dental Office with as much advance notice as practicable). Such rules, policies and procedures include, but are not limited to, those which govern the following: quality improvement/management; utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data; member grievances; and provider credentialing. Dental Office shall immediately update information it has on file with LIBERTY with respect to changes that occur outside of the re-credentialing cycle, including but not limited to changes in office hours, panel closings, changes in practitioners at an office, reduction in services and similar matters. Dental Office shall have the opportunity to review, and comment in writing to LIBERTY on, all dental protocols utilized by LIBERTY.

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

(a) Provide to LIBERTY an accurate and detailed description of all Covered Services rendered to Members on ADA Claim Forms and shall complete and submit such forms to LIBERTY as Covered Services are performed. Dental Office shall comply with all applicable clean claims requirements, in accordance with applicable law and regulations and as set forth in the most current LIBERTY Provider Reference Guide. LIBERTY shall acknowledge receipt of all claims, including the date LIBERTY received the claim. LIBERTY will notify Dental Office at least annually of the type of information and documentation that must be submitted with a claim, including a standard claim form and any other claim submission requirements

utilized by LIBERTY for both manually and electronically submitted claims. LIBERTY may change the required information and documentation as long as Dental Office is given at least thirty (30) days' prior notice of the change in the requirements.

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

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

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

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

2.4 Confidentiality.

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

(b) *LIBERTY Information.* Dental Office acknowledges that, by reason of its performance of services under this Agreement, Dental Office may have access to confidential and/or proprietary information of LIBERTY and of other third parties, including, without limitation, information and knowledge pertaining to products, services, benefits, policies, inventions, discoveries, improvements, innovations, designs, ideas, trade secrets, advertising, marketing, finances, distribution and sales methods, sales and profit figures,

databases, member, subscriber and provider lists, identifying information regarding members and subscribers, and relationships and agreements between LIBERTY and providers, regulators and others who have business dealings with them (collectively, "Confidential Information"). Dental Office acknowledges that such Confidential Information is a valuable and unique asset of LIBERTY and/or the other third parties to which such Confidential Information belongs, and Dental Office hereby covenants that during the term of this Agreement, Dental Office shall: (i) keep the Confidential Information in strictest confidence and use the Confidential Information for no other purpose than, and only to the extent necessary, to carry out its obligations under this Agreement; and (ii) not disclose any Confidential Information to any third party without the prior written authorization of LIBERTY. Upon termination or expiration of the Agreement, Dental Office shall return all such Confidential Information (except the Records, as defined below, which it has a duty to maintain) to LIBERTY. Following termination or expiration of the Agreement, Dental Office shall not in any way use or disclose the Confidential Information. The obligation of confidentiality imposed by this Section 2.4(b) ("LIBERTY Information") shall not apply to Confidential Information that is publicly known and generally available to the public through no act or omission of Dental Office or which is required to be disclosed by validly issued subpoena, by order of a court of competent jurisdiction or by applicable law or other legal or governmental process (collectively, "Required Disclosure"); provided, however, that in the case of Required Disclosure, Dental Office shall immediately provide written notice to LIBERTY of such request(s) and shall use reasonable efforts to resist disclosure until an appropriate protective order may be sought by, or a waiver of compliance with the terms of this Agreement has been granted by, LIBERTY. In the absence of a protective order or receipt of a waiver hereunder, if Dental Office is nonetheless, in the written opinion of its counsel, legally required to disclose the Confidential Information, then Dental Office may disclose such information, provided that LIBERTY has been given a reasonable opportunity to review the text of such disclosure before it is made and that disclosure is limited to only the Confidential Information specifically required to be disclosed.

2.5 Inspection, Evaluation, Audit; Document Retention.

(a) *Access to Records.* Dental Office shall permit LIBERTY and all applicable governmental agencies or divisions (and/or the designees of LIBERTY or such governmental agency/division), including but not limited to DOBI, to inspect, evaluate and audit any physical facilities and equipment, books, contracts, documents, papers, records, including dental records and documentation of the Dental Office that pertain to the Member, any aspect of Covered Services performed, reconciliation of benefits and determination of amounts payable (the "Records"). Dental Office shall cooperate and assist with, and provide the Records to, LIBERTY and any applicable governmental agency/division (and/or their designees) for purposes of the above inspections, evaluations, and /or audits, as requested. Dental Office may not make the access described in this Section 2.5(a) ("Access to Records") contingent upon a confidentiality statement or agreement. The above-described rights to inspect, evaluate and audit will extend through the period during which Dental Office is required to maintain the Records as set forth in Section 2.5(b) ("Retention Period") below. Dental Office shall provide all available Member medical records and other personally identifiable information to LIBERTY, with appropriate consent/authorization by the Member, for purposes including but not limited to preauthorization, concurrent review, quality assurance, payment processing and qualification for government programs and analysis and recovery of overpayments due to fraud and abuse, and Dental Office shall also provide such records and information to the State Department of Health, at no expense to the State, for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals and as otherwise required by state law. Dental Office shall also provide to LIBERTY and to the State, at no expense to the State and upon request, all financial data, reports and information concerning the appropriateness and quality of services provided, to the extent authorized by law.

(b) *Retention Period.* Dental Office shall maintain the Records for the later of: (i) ten (10) years from the termination or expiration of the Agreement or longer if required by law; (ii) seven (7) years after the last date of service; or (iii) in the case of a minor, the later of three (3) years after such minor reaches

majority or seven (7) years after the last date of service. Diagnostic and study models used for definitive treatment shall be maintained for at least three years from the date the model is made. Working models may be maintained.

2.6 Hold Harmless. Dental Office agrees that in no event, including but not limited to nonpayment by LIBERTY, payment by LIBERTY that is other than what Dental Office believed to be in accordance with the reimbursement provision of the Agreement or is otherwise inadequate, insolvency of LIBERTY, or breach of this agreement, shall Dental Office bill, charge or collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or a person (other than the health carrier or intermediary) acting on behalf of the Member for services provided pursuant to this Agreement. This Agreement does not prohibit Dental Office from collecting Cost Sharing, as specifically provided in the evidence of coverage. Nor does this Agreement prohibit Dental Office (except for a health care professional who is employed full-time on the staff of LIBERTY and has agreed to provide services exclusively to LIBERTY's Members and no others) and a Member from agreeing to continue services solely at the expense of the Member, as long as Dental Office has clearly informed the Member that LIBERTY may not cover or continue to cover a specific service or services.

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

2.8 Indemnification. LIBERTY shall not be liable for any act or omission by Dental Office or by any Dental Office Agents in connection with, or arising out of, the performance or nonperformance of any services by Dental Office/Dental Office Agents with respect to Members ("Dental Office Acts/Omissions"). Dental Office shall indemnify, defend and hold harmless LIBERTY (and LIBERTY's affiliates, subsidiaries, parent corporations, officers, directors, shareholders, managers, members and employees) from and against any and all losses, costs, damages, obligations, liabilities, awards and expenses (including, without limitation: defense costs; reasonable attorney's fees; court costs; exemplary damages, including but not limited to compensatory, consequential and punitive damages; penalties and fines; and interest), which arise out of or are in any way related to: (i) any Dental Office Acts/Omissions; (ii) Dental Office's (or a Dental Office Agent's) breach of this Agreement; or (iii) any representations, warranties, covenants, agreements, obligations, or acknowledgments of Dental Office or a Dental Office Agent as set forth in this Agreement (including but not limited to any provider application form). LIBERTY agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for LIBERTY's own acts or omissions, by indemnification or otherwise, to a dentist.

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

Member's dental needs, the termination of this Agreement to the extent it affects the Member or the coverage of dental services, subject to the terms set forth in Section 6.2 of this Agreement ("Communications").

2.10 Compliance with Laws and Regulations. Dental Office agrees to comply with all applicable federal and state laws, rules and regulations, as may be amended from time to time. Notwithstanding any other provision of this Agreement, the Parties shall also comply with the provisions of the Managed Care Reform Act of 1996, specifically Chapter 705 of the Laws of 1996, Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007 and Chapter 237 of the Laws of 2009, including all amendments thereto. In addition, the Parties shall also comply with all applicable requirements of the Federal Americans with Disabilities Act (ADA).

ARTICLE III: QUALITY ASSURANCE

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

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

3.3 Radiology Equipment. If Dental Office utilizes radiology or radiographic equipment at its facility in rendering services pursuant to this Agreement, Dental Office shall have such equipment regularly checked by local or state health authorities or a radiation physicist to ensure that such equipment is environmentally safe and technologically accurate. Any hazards identified by such inspections or at any time shall be promptly corrected. Dental Office shall maintain equipment maintenance and calibration records and all inspection certificates or reports, all of which records, certificates and reports shall be available for review by LIBERTY upon request. In addition, Dental Office shall (and shall ensure all applicable Agents) possess and maintain any licenses required to operate such equipment in accordance with applicable laws and regulations, including but not necessarily limited to NJSA 26:2D-27.

ARTICLE IV: COMPENSATION

4.1 Fees. In exchange for the provision of Covered Services to Members, Dental Office shall be compensated in accordance with the applicable fees set forth in Exhibit A or as set forth in the applicable compensation addendum or fee schedule provided by LIBERTY or mutually agreed upon by the Parties. Dental Office acknowledges and agrees that all such fees will be based on the current, applicable Dental Plan(s). Dental Office agrees to accept such fees and any applicable Cost Sharing as payment in full for the rendered Covered Services. There shall be no financial incentive(s) paid to Dental Office for the withholding of medically necessary dental services under this agreement.

4.2 Discounts. If Dental Office discounts or waives any portion, or all, of a Member's Cost Sharing, Dental Office shall report such discounted fee or Cost Sharing waiver on the claim form being submitted to LIBERTY.

4.3 Coordination of Benefits. 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.

ARTICLE V: TERM AND TERMINATION

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

5.2 Termination.

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

(b) *By either party.* Either Party may exercise a right of non-renewal of the Agreement upon written notice provided to the other Party at least ninety (90) days prior to the end of the Term or Renewal Term.

(c) *By LIBERTY.* LIBERTY may also terminate this Agreement as follows:

i. *Immediate termination.* LIBERTY may terminate this Agreement immediately and without possibility of reinstatement upon cure if: (i) LIBERTY determines that Dental Office presents an imminent danger to a Member or to public health, safety or welfare, (ii) LIBERTY determines that Dental Office has committed fraud, or (iii) there has been a final disciplinary action by a state licensing board or other governmental agency that impairs Dental Office's ability to practice. To the extent any of the foregoing occurrences involve only a particular dentist or dentists of Dental Office, LIBERTY may, in its sole discretion, immediately (and without possibility of reinstatement upon cure) terminate such dentist or dentists' participation under this Agreement or under a specific Dental Plan.

ii. *Termination upon notice.* Either party may also terminate this Agreement upon at least ninety (90) days' written notice. If to Dental Office, the notice shall provide the reason(s) for the proposed action and shall specify that Dental Office may request in writing a hearing within ten (10) business days following the date of receipt of the notice of termination, which hearing shall occur prior to the date of termination from LIBERTY's network. LIBERTY shall provide in writing the reasons for the termination, if requested by Dental Office, within no more than fifteen (15) days of receipt of the request if the reason is not otherwise stated in the written notice of termination. No such right to a hearing shall exist with respect to terminations described in subparagraph i. ("Immediate termination") above. LIBERTY shall hold a hearing within thirty (30) days following receipt of a written request for a hearing by a terminated Dental Office before a panel appointed by LIBERTY.

Under no circumstances may LIBERTY terminate a Dental Office based on Dental Office's filing complaints or appeals in his or her own behalf or on behalf of a Member or for otherwise acting as an advocate of Member in seeking appropriate, medically necessary health care services covered by the Member's Dental Plan.

5.3 Effect of Termination.

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

(b) *Benefit Continuation; Completion of Work.* In the event of termination or expiration of this Agreement, Dental Office agrees to assist LIBERTY in the orderly transfer of Members to another provider.

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

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

ARTICLE VI: GENERAL PROVISIONS

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

6.2 Communications. Any written mass communication relating to LIBERTY or its Dental Plans (whether or not LIBERTY is specifically named) directed to Members by Dental Office must be reviewed and approved by LIBERTY prior to mailing. If Dental Office fails to submit such communications to LIBERTY for prior approval, LIBERTY may terminate this Agreement in accordance with Section 5.2 ("Termination"). Nothing herein shall prohibit Dental Office from openly communicating with Members about all appropriate diagnostic testing and treatment options.

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

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

6.5 Dispute Resolution Process. Any dispute, claim or controversy between the Parties arising out of or relating to this Agreement shall be resolved by mediation or in the event such dispute, claim or controversy cannot be

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

6.6 Miscellaneous.

a) *Applicable Law; Venue.* This Agreement and the rights and obligations of the parties hereto shall be interpreted, construed and enforced in accordance with the laws of the State of New Jersey, without giving effect to principles of conflicts of laws. Each Party agrees that any suit, action or proceeding against the other party arising out of or relating to this Agreement will be brought in any federal or state court located in New Jersey, and each Party hereby submits to the exclusive jurisdiction of such courts for the purpose of any such suit, action or proceeding.

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

c) *Entire Agreement.* This Agreement (including any applicable provider application, any applicable provider manual including the Provider Reference Guide, and all applicable attachments, exhibits, addenda and fee schedules) is the final expression of, and contains the entire agreement between, the Parties with respect to the subject matter hereof and supersedes all prior communications or understandings with respect thereto.

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

e) *Amendments.* The Parties acknowledge and agree that this Agreement may be required to be modified from time to time, without Dental Office's consent, in order to comply with applicable federal and state laws or regulations. In that regard, the Parties agree that any changes in applicable law that do not require this Agreement to be modified by a written amendment shall be automatically incorporated herein and that, where any changes in applicable law require this Agreement to include or not include certain language or provisions, such modification to language or provisions shall occur automatically without the need for the Parties to execute any amendment to this Agreement. In addition, LIBERTY may remove, amend, modify or supplement any term or provision of this Agreement (including the addition of addenda and/or exhibits) upon not less than thirty (30) calendar days' written notice to Dental Office; if Dental Office fails to object to such modification in writing within ten (10) days of such notification, Dental Office will be deemed to have consented to such modification. Except for the foregoing, this Agreement may not otherwise be amended, modified, changed, or supplemented in any way except by written instrument signed by an authorized signatory of each Party.

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

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

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

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

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

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

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

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

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

To LIBERTY:
LIBERTY Dental Plan of New Jersey, Inc.
Attn: Professional Relations
340 Commerce, Suite 100
Irvine, CA 92602

To Dental Office:
Address specified on signature page

[Signatures on Next Page]

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

("Dental Office"):	**LIBERTY Dental Plan of New Jersey, Inc. ("LIBERTY"):**
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 Dental Office License #	
SS# and/or Tax ID#	
Individual National Provider Identifier (NPI)	
Organizational National Provider Identifier (NPI) *(if applicable)*	

NEW JERSEY MEDICAID ADDENDUM

This NEW JERSEY MEDICAID ADDENDUM (the "Addendum") to the Provider Agreement (the "Agreement") entered into by and between LIBERTY Dental Plan of New Jersey, Inc. ("LIBERTY**"**), a subsidiary of LIBERTY Dental Plan Corporation, and the legal entity or individual qualified and licensed to practiced dentistry in the state of New Jersey as defined in the Agreement and as specified on the signature page of this Addendum ("Dentist**"**) is meant to supplement the Agreement. LIBERTY and Dentist may each be referred to as a "Party" and together, may be referred to as the "Parties." 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. Dentist acknowledges that the following provisions are required for participation in New Jersey Medicaid managed care and FamilyCare programs (together, the "Programs"); accordingly, should this Addendum expire or terminate, Dentist shall not be permitted by LIBERTY to participate in the Programs. LIBERTY and Dentist hereby agree as follows:

1. Definitions.

"Dental Services" means any diagnostic, preventive, or corrective procedures administered by or under the direct personal supervision of a dentist in the practice of Dentist's profession. Such services include treatment of the teeth, associated structures of the oral cavity and contiguous tissues, and the treatment of disease, injury, or impairment which may affect the oral or general health of the individual. Such services shall maintain a high standard for quality and shall be within the reasonable limits of those services which are customarily available, accepted by, and provided to most persons in the community within the limitations, and exclusions hereinafter specified.

Dental services should be provided in accordance with N.J.A.C. 10:56 and should include preventive, diagnostic, major and minor restorative, endodontic, surgical, and adjunctive services, periodontic, and prosthodontic services, provided by or under the supervision of a dentist in the practice of his or her profession, including treatment of:

a) the teeth and associated structures of the oral cavity; and
b) disease, injury, or impairment that may affect the oral or general health of the enrollee.

Orthodontic services are only to be provided to children in cases where medical necessity can be proven, such as cases involving developmental and facial deformities or functional difficulties in speech and mastication, and trauma. Orthodontic treatment will refer to limited, interceptive, and comprehensive orthodontic treatment as well as all other ancillary orthodontic services, with these services being considered only when the medical criteria for exemptions as noted above have been met.

Continuity of care to case completion will apply with continued eligibility.

Medical and surgical services of a dentist provided by a doctor of dental medicine or dental surgery are services that:

a) if furnished by a physician, would be considered physician's services;
b) may be furnished either by a physician or by a doctor of dental medicine or dental surgery; and
c) are furnished by a doctor of dental medicine or dental surgery who is authorized to furnish those services in New Jersey or in the state where he/she practices.

"Non-routine Dental Service" means any dental service that requires prior authorization in order to be reimbursed.

"Non-covered Services" means those services not covered by the Programs, such as procedures which are primarily for cosmetic purposes, for which dental necessity cannot be demonstrated, or which are otherwise determined to be beyond the scope of the Programs. Medical/dental supplies and equipment and other devices that are essential for the Member's medical/dental condition shall be allowable unless such services are otherwise available at no charge from community services (such as the American Cancer Society or other

service organizations), and standard tooth brushes, dental floss, and like items are considered personal hygiene items and shall not be covered by the Programs.

2. **Program Performance Standards.** Dentist agrees that the work it performs under the Agreement with respect to the Programs will conform to the terms of the Medicaid managed care contract (the "Medicaid Contract"). LIBERTY shall monitor the performance of Dentist. If Dentist's performance does not meet the standards set forth in the Medicaid Contract or LIBERTY identifies deficiencies or areas of needed improvement in Dentist's performance, Dentist shall take immediate corrective action. In addition, if Dentist's performance does not meet such standards, LIBERTY may terminate this Addendum and/or impose sanctions upon Dentist.

3. **Prior authorization.** In the case of Non-routine Dental Services which require prior authorization, the requisite prior authorization documents (*i.e.*, the Dental Prior Authorization Form and the Dental Claim Form) shall be submitted to LIBERTY along with the treatment plan and any additional documentation or radiographs appropriate to the request. A LIBERTY dental consultant may modify or deny Dentist's treatment plan in accordance with the requirements of the Programs. Such modifications or denials are designed to provide dental treatment to the Member that is adequate for the correction of the problem, that can be expected to last for the longest period of time, and represents, in the opinion of the dental consultant(s), the most judicious application of Program reimbursement. If in the professional judgment of Dentist such modification is not appropriate, Dentist may request another review by the dental consultant. A further review in the Bureau of Dental Services may be requested through the dental consultant.

   In any dental treatment or services plan, Dentist shall discuss the proposed treatment plan and receive approval from the Member and/or the Member's family member/guardian before submission for authorization and again after authorization is received and prior to initiation of treatment. It is suggested that Dentist have the Member sign the office records or a separate statement that the treatment plan meets with their approval, since no alteration of the treatment plan will be reimbursed based on the subsequent rejection of all or part of that treatment plan by the Member or the Member's family member/guardian.

   Consideration for development of a dental treatment plan shall be based upon the least costly treatment fulfilling the requirements of the specific situation. On the basis of post-utilization review, any dental treatment plan, including those not requiring prior authorization, may be reviewed by LIBERTY dental consultants to determine appropriateness of treatment. If the treatment is not appropriate, the payment shall be recovered.

   If, in the opinion of Dentist, the Member requires the services of a specialist, Dentist shall note the name of the practitioner to whom the Member is being referred on the Dental Claim Form under remarks. The specialist shall note the name and Medicaid/NJ FamilyCare Provider Service Number of the referring dentist on the Dental Claim Form, which is designated as Referring Practitioner.

4. **Confidentiality.** In addition to all confidentiality obligations set forth in the Agreement and those required by applicable law, Dentist shall comply with all confidentiality requirements set forth in the Medicaid Contract.

5. **LIBERTY Actions.** With respect to Dentist's participation in the Programs, LIBERTY shall not impose obligations and duties on Dentist that are inconsistent with the Medicaid Contract, or that impair any rights accorded to the New Jersey State Department of Human Services (SDHS), the Division of Medical Assistance and Health Services (DMAHS) or the United States Department of Health and Human Services (DHSS).

6. **Access to Records.** LIBERTY and the SDHS, DMAHS, DHSS or their agents shall have access to Dentist's medical/dental records, encounter data and financial information. These records shall be available for a minimum of seven (7) years following the last date of service.

7. **Use of Federal Funds.** Dentist shall not use Federally appropriated funds for lobbying and shall, in the case of contracts that exceed one hundred thousand dollars ($100,000), make all certifications and disclosures required by applicable law and the Medicaid Contract.

8. **Disclosures.** Dentist shall disclose to LIBERTY complete ownership, control and relationship information. In addition, Dentist shall disclose to LIBERTY, on an ongoing basis, any managing employee that has been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or the Title XX services program. Dentist shall monitor employees and staff against the "List of Excluded Individuals and Entities" (LEIE) and excluded individuals or disqualified providers posted by the New Jersey Medicaid Fraud Division of the Office of the State Comptroller (MFD) on its Website. LIBERTY is required, within thirty-five (35) days of a request by SDHS, DMAHS, MFD or DHHS, to obtain from any subcontractor disclosure of ownership and with whom an individual network provider has had a business transaction totaling more than twenty-five thousand dollars ($25,000) during the twelve-month (12-month) period ending on the date of request; accordingly, Dentist agrees to assist LIBERTY in complying with any such request.

9. **Member and SDHS/DMAHS Non-liability.** Dentist agrees that in no event, including, but not limited to, nonpayment by LIBERTY, insolvency of LIBERTY, or breach of this Agreement, shall Dentist bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or person (other than LIBERTY) acting on his/her behalf, for services provided pursuant to the subscriber contract or Medicaid Contract and the Agreement. In addition, in the case of Medicaid managed care, Dentist agrees that, during the time of Member's enrollment/membership, Dentist will not bill SDHS for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the agreement between the SDHS and the Medicaid managed care organization under contract with the SDHS or DMAHS (the "MCO"). This provision shall not prohibit Dentist from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the applicable evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a Member, provided that Dentist shall have advised the Member in writing prior to providing the service that the service is uncovered and of his/her liability therefore.

10. **Coordination of Benefits.** Dentist shall maintain and make available to LIBERTY records that reflect coordination of benefits proceeds collected by Dentist or paid directly to the Members by third party payers and amounts thereof, and LIBERTY shall maintain or have immediate access to records concerning collection of coordination of benefit proceeds. LIBERTY shall exhaust all other sources of payment prior to remitting payment for a Member.

11. **Developmental Disabilities.** LIBERTY shall develop specific policies and procedures for the provision of Dental Services to enrollees with developmental disabilities

12. **Reimbursement.** Dentist shall be reimbursed for covered Dental Services in accordance with the fees agreed upon by LIBERTY and Dentist, which fees shall be no less than the corresponding Program reimbursement fees. A fee will be paid only for covered Dental Services rendered. If a Member does not return for completion of the treatment plan, only those services provided shall be billed. If circumstances involving a Member, over which Dentist has no control, preclude completion of a service and/or authorized appliance, Dentist will be reimbursed an amount consistent with the stage of completion of the authorized service and/or appliance. Experimental procedures not approved by the New Jersey Board of Dental Examiners are not reimbursable.

13. **Utilization review, quality control, dental review peer review, and TAMI review.** Utilization review, quality control and peer review are considered to be ongoing components in regard to the Dental Services provided to Members in accordance with N.J.A.C. 10:56-1.10. Dentist shall cooperate and participate in LIBERTY's quality management and utilization management system, including credentialing/recredentialing; appointment standards; and Member and provider complaint and grievance system.

14. **Term; Termination.** This Addendum shall be coterminous with the Agreement, shall automatically terminate upon expiration or termination of the Agreement, and shall be subject to the same termination provisions as set forth in the Agreement. Notwithstanding any other provision in the Agreement, to the extent that Dentist is providing services to Members under the Programs, LIBERTY retains the option to immediately terminate the Agreement if, and when, Dentist has been terminated or suspended from participation in either of the Programs or when such Dentist materially misrepresents the provisions, terms, or requirements of LIBERTY or the MCO. LIBERTY shall not terminate the Agreement with Dentist because Dentist expresses disagreement with LIBERTY's decision to deny or limit benefits to a Member or because Dentist assists the Member to seek reconsideration of LIBERTY's decision; or because Dentist discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by LIBERTY or not, policy provisions of a plan, or Dentist's personal recommendation regarding selection of a health plan based on Dentist's personal knowledge of the health needs of such patients.

    Dentist shall be precluded from making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature that is false or maliciously critical of the MCO or LIBERTY and calculated to injure the MCO or LIBERTY.

15. **Insurance.** In addition to the insurance coverage required under the Provider Agreement, Dentist shall agree that any insurance obtained by Dentist shall not limit Dentist's indemnification of the State and Members.

16. **Encounter Data.** Dentist must submit encounter data to LIBERTY which, at a minimum, shall include profiling that includes complete and timely submissions of encounter data and shall meet data submission specifications and requirements based on encounter data elements for which compliance performance will be both rewarded and/or sanctioned.

17. **Monitoring.** Dentist hereby acknowledges that the responsibilities performed by Dentist are monitored on an ongoing basis and that the MCO is ultimately responsible to the SDHS and DMAHS for the performance of all services and that such performance is consistent with the Medicaid managed care contract between the MCO and the SDHS and DMAHS. The MCO and LIBERTY shall have the right to revoke Dentist's Provider Agreement if Dentist does not perform satisfactorily or if the SDHS or DMAHS may require the MCO to terminate Dentist if his or her performance is not consistent with the contract between the MCO and the SDHS and DMAHS.

18. **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.

19. **Amendments; Conflicting Terms.** To the extent LIBERTY enrolls Members covered by the Programs, this Addendum incorporates the pertinent managed care obligations under the Medicaid Contract between the MCO and the SDHS or DMAHS as if set forth fully herein. The terms set forth in such contracts as well as the terms set forth in this Addendum are expressly incorporated into this Agreement and are binding upon the Parties. In the event of any inconsistent or contrary language between the provisions of the Agreement and the Addendum, including but not limited to appendices, amendments and exhibits, the Parties agree that the provisions of the Addendum shall prevail with respect to Dentist's participation in the Programs under the Agreement, except to the extent applicable law requires otherwise and/or to the extent a provision in the Agreement exceeds the minimum requirements set forth in this Addendum.

20. **Required language.** Dentist agrees to serve Members in New Jersey's managed care program and, in doing so, to comply with all of the provisions set forth in Appendix A to this Agreement.

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

("Dentist"):	**LIBERTY Dental Plan of New Jersey, Inc. ("LIBERTY"):**
Authorized Signature	Signature
Print Name	Print Name
Title	Title
Date	Effective Date
Individual Medicaid Number	
Group Medicaid Number (if applicable)	

APPENDIX A
Required Language

The provider/subcontractor agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions:

A. SUBJECTION OF PROVIDER CONTRACT/SUBCONTRACT

This provider contract/subcontract shall be subject to the applicable material terms and conditions of the contract between the Contractor and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Contractor.

MLTSS Any Willing Provider and Any Willing Plan. Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with the Contractor's provider network requirements shall be included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. The Contractor must accept all NFs, SCNF, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid Providers, and network participation of these provider types cannot be denied based on the application of a subjective standard.

1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be for a two year period from the date that the service comes into MLTSS, dependent upon available appropriation in each Fiscal Year. For NF, SCNF, AL and CRS that would mean that AnyWilling Provider status expires on June 30, 2016. Thereafter the Contractor may determine the continuing provider network status of these provider types based on Member utilization and access needs. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers.

2. The Any Willing Plan status also expires June 30, 2016.

3. Long term care pharmacy status as an Any Willing Provider shall not expire. The Contractor shall pay long term care pharmacies the rate negotiated between the Contractor and the pharmacy.

Claims payment for services to MLTSS Members. The Contractor shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facility, CRS providers, adult/pediatric medical day care providers, PCA and participant directed Vendor Fiscal/Employer Agent Financial management Services (VF/EA FMS) claims within the following timeframes:

1. HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) calendar days of receipt;

2. Manually submitted clean claims shall be processed within thirty (30) calendar days of receipt.

B. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

The provider/subcontractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and

requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

1. The Provider/Subcontractor shall submit claims within 180 calendar days from the date of service.

2. The Provider/Subcontractor shall submit corrected claims within 365 days from the date of service.

3. The Provider and Subcontractor shall submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

C. APPROVAL OF PROVIDER CONTRACTS/SUBCONTRACTS AND AMENDMENTS

The provider/subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract/subcontract and any amendments thereto.

1. The contractor and AWP provider shall only amend this provider contract unilaterally for statutory and regulatory changes, and upon mutual consent of the parties with State approval.

D. EFFECTIVE DATE

This provider contract/subcontract shall become effective only when the Contractor's agreement with the State takes effect.

E. NON-RENEWAL/TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT

The provider/subcontractor understands that the Contractor shall notify DMAHS at least 30 days prior to the effective date of the suspension, termination, or voluntary withdrawal of the provider/subcontractor from participation in the Contractor's network. If the termination was "for cause," as related to fraud, waste, and abuse, the Contractor's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless the Contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

F. ENROLLEE-PROVIDER COMMUNICATIONS

1. The Contractor shall not prohibit or restrict the provider/subcontractor subcontractor from engaging in medical communications with the provider's/ subcontractor's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider/subcontractor and the provider's/subcontractor's patient. Providers/subcontractor shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractor s shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in section F.1 shall be construed:

   a. To prohibit the enforcement, including termination, as part of a provider contract/subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the Contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such

utilization do not prohibit or restrict medical communications between providers/subcontractors and their patients; or

b. To permit a health care provider to misrepresent the scope of benefits covered under this provider contract/subcontractor or to otherwise require the Contractor to reimburse providers/subcontractors for benefits not covered.

G. RESTRICTION ON TERMINATION OF PROVIDER CONTRACT/ SUBCONTRACT BY CONTRACTOR

Termination of AWP providers is limited to State ordered termination as indicated Section H below. The Contractor shall not terminate this provider contract/subcontract for either of the following reasons:

1. Because the provider/subcontractor expresses disagreement with the Contractor's decision to deny or limit benefits to a covered person or because the provider/subcontractor assists the covered person to seek reconsideration of the Contractor's decision; or because the provider/subcontractor discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the Contractor or not, policy provisions of the Contractor, or the provider/subcontractor's personal recommendation regarding selection of a health plan based on the provider/subcontractor's personal knowledge of the health needs of such patients.

2. Because the provider/subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because the provider/subcontractor practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT – STATE

The provider/subcontractor understands and agrees that the State may order the termination of this provider contract/subcontract if it is determined that the provider/subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;

2. Takes any action that threatens the fiscal integrity of the Medicaid program;

3. Has its certification suspended or revoked by DOBI, DOH, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;

4. Becomes insolvent or falls below minimum net worth requirements;

5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;

6. Materially breaches the provider contract/subcontract; or

7. Violates state or federal law, including laws involving fraud, waste, and abuse.

I. NON-DISCRIMINATION

The provider/subcontractor shall comply with the following requirements regarding nondiscrimination:

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with

Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

2. ADA Compliance. The provider/subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the provider/subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are "qualified individuals with a disability" covered by the provisions of the ADA. The Contractor shall supply a copy of its ADA compliance plan to the provider/subcontractor.

   A "qualified individual with a disability" as defined pursuant to 42 U.S.C.§12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

   The provider/subcontractor shall submit to [insert name of HMO] a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that the provider/subcontractor meets ADA requirements to the best of the provider/subcontractor's knowledge. The provider/subcontractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the provider/subcontractor to be in compliance with the ADA. Where applicable, the provider/subcontractor must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

3. The provider/subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the provider/subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4. The provider/subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10: 2-1 through N.J.S.A. 10: 2-4, N.J.S.A. 10: 5-1 et seq. and N.J.S.A. 10: 5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. The provider/subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this provider/subcontractor contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

5. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127.

6. Grievances. The provider/subcontractor agrees to forward to [insert HMO name] copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by the provider/subcontractor.

J. OBLIGATION TO PROVIDE SERVICES AFTER THE PERIOD OF THE CONTRACTORCONTRACTOR'S INSOLVENCY AND TO HOLD ENROLLEES AND FORMER ENROLLEES HARMLESS

1. The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the Contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.

2. The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the Contractor or the state, insolvency of the Contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in section 2.P.

3. The provider/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the Contractor, and shall be construed to be for the benefit of the Contractor or enrollees.

4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.

5. The provider/subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.

6. The provider/subcontractor shall comply with the prohibition against billing Members contained in 42 CFR 438.106, N.J.S.A. 30:4D-6.c, and N.J.A.C. 10:74-8.7.

K. INSPECTION

The provider/subcontractor shall allow the New Jersey Department of Human Services, the U.S. Department of Health and Human Services (DHHS), MFD, and other authorized State agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the provider contract/subcontract, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by the provider/subcontractor pertaining to such services, at any time during normal business hours (and after business hours when deemed necessary by DHS or DHHS, or MFD) at a New Jersey site designated by the State. Inspections may be unannounced for cause.

The subcontractor shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by the provider/subcontractor, prior to approval of their use for providing services to enrollees.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this provider contract/subcontract, including working papers, reports, financial records and books of account, medical records, dental records, prescription files, provider contracts and subcontracts, credentialing files, and any other documentation pertaining to medical, dental, and nonmedical services to enrollees. Upon request, at any time during the period of this provider contract/subcontract, the provider/subcontractor shall furnish any such record, or copy thereof, to the Department or the Department's External Quality Review Organization within 30 days of the request. If the Department determines, however, that there is an urgent need to obtain a record, the Department shall have the right to demand the record in less than 30 days, but no less than 24 hours.

The DMAHS, the MFD, or its designee, and the MFCU, shall have the right to inspect, evaluate, and audit all of the following documents in whatever form they are kept, related to this contract:

1. Financial records, including but not limited to tax returns, invoices, inventories, delivery receipts, Medicaid claims;

2. Medical records, including but not limited to medical charts, prescriptions, x-rays, treatment plans, medical administration records, records of the provision of activities of daily living, ambulance call reports;

3. Administrative documents, including but not limited to credentialing files, appointment books, prescription log books, correspondence of any kind with Contractor, DMAHS, CMS, any other managed care Contractor, Medicaid recipient, contracts with subcontractors, and contracts with billing service providers; and

4. All records required to be kept to fully disclose the extent of services provided to Medicaid recipients, pursuant to NJAC 10:49-9.8(b) (1).

L. RECORD MAINTENANCE

The provider/subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

M. RECORD RETENTION

The provider/subcontractor hereby agrees to maintain an appropriate recordkeeping system for services to enrollees. Such system shall collect all pertinent information relating to the medical management of each enrolled beneficiary and make that information readily available to appropriate health professionals and the Department. Records must be retained for the later of:

1. Five (5) years from the date of service, or

2. Three (3) years after final payment is made under the provider contract/subcontract and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality.

If an enrollee disenrolls from the Contractor, the provider/subcontractor shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the enrollee.

N. DATA REPORTING

The provider/subcontractor agrees to provide all necessary information to enable the Contractor to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

O. DISCLOSURE

1. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the Contractor’s agreement with the State.

2. The provider/subcontractor shall comply with financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.

3. The provider/subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106 and complete a Disclosure Statement which will be maintained by the Contractor.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A, B and B ABP enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare D enrollees shall be collected in accordance with the attached schedule.

Q. INDEMNIFICATION BY PROVIDER/SUBCONTRACTOR

1. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

2. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

3. The provider/subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the provider/subcontractor receives payment.

4. The provider/subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such data that the provider/subcontractor inserts.

5. The provider/subcontractor shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the provider/subcontractor, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. The provider/subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the subonctracor/provider.

R. CONFIDENTIALITY

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the Contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.4. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the Contractor's plan that are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by the provider/subcontractor, it: (a) shall not use any such information for any purpose other than carrying out the express terms of this provider contract/subcontract; (b) shall promptly transmit to the Department all requests for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the provider contract/subcontract, any such information to any party other than the Department without the Department's prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the provider contract/subcontract, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. The provider/subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within the provider's/subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this provider contract/subcontract.

5. The provisions of this article shall survive the termination of this provider contract/subcontract and shall bind the provider/subcontractor so long as the provider/subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, the provider/subcontractor is responsible for complying, at a minimum, with the following statues and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U>S>C> 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

S. CLINICAL LABORATORY IMPROVEMENT

The provider/subcontractor shall ensure that all laboratory testing sites providing services under this provider contract/subcontract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

T. FRAUD, WASTE, AND ABUSE

1. The provider/subcontractor agrees to assist the Contractor as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.

2. If the State has withheld payment and/or initiated a recovery action against the provider/subcontractor, or withheld payments pursuant to 42 CFR 455.23 and NJAC 10:49-9.10(a), the Contractor shall have the right to withhold payments from the provider/subcontractor and/or forward those payments to the State.

3. The Contractor and its providers, and subcontractors, whether or not they are enrolled Medicaid providers, shall cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, DMAHS, MFD, DOH, MFCU, HHS-OIG, FBI, DEA, FDA, and the U.S. Attorney's Office. The Contractor shall include language in its contracts with its providers and subcontractors, requiring cooperation, and stating that a failure to cooperate shall be grounds for termination of the Contractor's

agreement with the provider or subcontractor. Such cooperation shall include providing access to all necessary recipient information, medical and clinical information, correspondence, documents, computer files, and appropriate staff.

4. MFD shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with the Contractor, but reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request the Contractor to withhold payment to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by the Contractor shall be sent to MFD from the Contractor and reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS.

5. The Contractor shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations the Contractor solely conducts.

U. THIRD PARTY LIABILITY

1. The provider/subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.

2. Except as provided in subsection 3. below, if the provider/subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to the Contractor.

3. In the following situations, the provider/subcontractor may bill the Contractor first and then coordinate with the liable third party, unless the Contractor has received prior approval from the State to take other action.

    a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.

    b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.

    c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.

    d. The claim is for a child who is in a DCP&P supported out of home placement.

    e. The claim involves coverage or services mentioned in 3.a, 3.b, 3.c, or 3.d, above in combination with another service.

4. If the provider/subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the provider/subcontractor may bill the Contractor without having received a written denial from the third party.

5. Sharing of TPL Information by the Provider/Subcontractor.
    a. The provider/subcontractor shall notify the Contractor within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the Contractor, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage.

b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the Contractor in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the provider's/subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee's diagnosis and the nature of the service provided to the enrollee.

c. The provider/subcontractor shall notify the Contractor on no less than a weekly basis when it becomes aware of the death of one of its Medicaid enrollees age 55 or older, utilizing the "Combined Notification of Death and Estate Referral Form" located in subsection B.5.1 of the Appendix.

d. The provider/subcontractor agrees to cooperate with the Contractor's and the State's efforts to maximize the collection of third party payments by providing to the Contractor updates to the information required by this section.

V. ENROLLEE PROTECTIONS AGAINST LIABILITY FOR PAYMENT

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's sole recourse for payment, other than collection of any authorized cost-sharing, patient payment liability and /or third party liability, is the Contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family Member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:

   a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

   b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and

   c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i) , 42 CFR 438.114, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section 4.2.1D.2 of the contract), or NJAC 10:74-9.1; and

   d. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and

   e. The protections afforded to enrollees under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and

   f. The provider has received no program payments from either DMAHS or the Contractor for the service; or

   g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

   a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the Contractor's network; or

   b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

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***

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.

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 Credentialing Application

*Required Fields

Please complete one application per Provider.

CREDENTIALING INFORMATION:

☐ **Owner** ☐ **Associate**

***PROVIDER NAME:** _____ ☐ DDS ☐ DMD ☐ Other (specify): _____

***DATE OF BIRTH:** ___/___/_____ **Gender:** ☐ Male ☐ Female

***DENTAL PRACTICE NAME (DBA):** _____

***PRIMARY PRACTICE ADDRESS:** _____

***CITY, STATE, ZIP:** _____ County: _____

***OFFICE PHONE #:** ( ) - **EMERGENCY PHONE #:** ( ) - ***FAX #:** ( ) -

Email Address:

***TAX IDENTIFICATION #:** _____ ***SOCIAL SECURITY #:** - -

* **NPI Type 1** (Individual): _____ NPI Type 2 (Organizational): _____

(More than one provider in the office requires an Organizational NPI Number)

Medicaid Provider? ☐ YES ☐ NO (If Yes, ALL NPI #'s must be registered with appropriate State Agency)

Provider State Medicaid Rendering #: _____ Provider State Medicaid Billing #: _____

EDUCATION INFORMATION:

***SPECIALTY TYPE:** ☐ General Dentist ☐ Endodontist ☐ Pediatric Dentist ☐ Periodontist
☐ Oral Surgeon ☐ Orthodontist ☐ Prosthodontist ☐ Other _____

***BOARD CERTIFIED:** ☐ YES ☐ NO (Please Check "NO" if not applicable. Do not leave blank.)

***DENTAL SCHOOL ATTENDED**: _____ **MONTH / *YEAR GRADUATED:** ___/_____

***CITY**: _____ State: _____ Country: _____

Specialty School Attended: _____ **MONTH / YEAR GRADUATED:** ___/_____

City: _____ State: _____ Country: _____

***Do you have Hospital Privileges?** ☐ YES ☐ NO (Please Check "NO" if not applicable. Do not leave blank.)

Hospital Name: City/State/Zip: Phone #: ( ) -

*Do you have current and valid state issued permits to administer Oral, Enteral, Parenteral, Intravenous, Inhalation, Conscious and/or Pediatric Conscious Sedation? ☐ YES ☐ NO

IF YES, please check all permits that you maintain and that apply to your licensure in the state you are applying for:

☐ Oral/Enteral Sedation ☐ Parenteral Sedation ☐ Intravenous Sedation ☐ Inhalation Sedation
☐ General Anesthesia ☐ Conscious Sedation ☐ Pediatric Conscious Sedation

Alternative Languages Spoken?

LICENSURE and PROFESSIONAL LIABILITY INFORMATION:

***Please attach a copy of your current:** 1) Dental License 2) DEA 3) Malpractice Insurance Cert showing Professional Liability*

***LICENSE #:** _____ State: _____ ***EXPIRATION DATE**: _____

***DEA #:** _____ ***EXPIRATION DATE**: _____

***MALPRACTICE INSURANCE CARRIER:** _____ ***EXPIRATION DATE**: _____

***POLICY #:** _____ ***AMOUNT OF LIABILITY:** $ /$ _____

*5 YEAR WORK HISTORY:

Please supply a 5 Year Work History including your **current dental practice location** and any GAPS in employment of 6 months or longer. Dates must show **Month** and **Year**.

1. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** **CURRENT**

2. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** MONTH / YEAR ___/_____

3. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** MONTH / YEAR ___/_____

4. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** MONTH / YEAR ___/_____

5. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** MONTH / YEAR ___/_____

6. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** MONTH / YEAR ___/_____

***PROFESSIONAL QUESTIONS and ATTESTATIONS: (ALL questions must be answered)**

For each "YES" response please include a detailed explanation with this form.
Please check "NO" for any questions that are NOT APPLICABLE.

1. In the past five (5) years, have you had any gaps of six (6) months or greater, where you did not work as a practitioner in this current discipline? If "YES", please provide the reason(s) for any gap(s) on a separate page. Please mark "NO", if any gaps occur between education and employment.
   ☐ **YES** ☐ **NO**
2. Has your license(s) to practice in any jurisdiction(s), whether completed or still pending, ever been denied, limited, suspended, revoked, not renewed, or have you ever been placed under probation, subject to disciplinary action or have you voluntarily relinquished any item in anticipation of any of these actions?
   ☐ **YES** ☐ **NO**
3. Has your professional liability insurance ever been denied, suspended, canceled, or subjected to any disciplinary action?
   ☐ **YES** ☐ **NO**
4. Have any of your DEA or State Drug Certificate registrations ever been denied, suspended, canceled, or subjected to any disciplinary action?
   ☐ **YES** ☐ **NO**
5. Has your status as a provider or membership with any professional organization, ever been denied, suspended, canceled, sanctioned, or subjected to any disciplinary action? Are you currently under investigation by any municipal, state, federal or any other government agency, HMO, PPO or other prepaid health plan? (e.g. Medicare, Medicaid)
   ☐ **YES** ☐ **NO**
6. Are your privileges or memberships at any hospital or institution (military service) currently under investigation or have they ever been denied, suspended, reduced, disciplined, or not renewed?
   ☐ **YES** ☐ **NO**
7. Are you prevented from performing any procedures within the scope of privileges and duties as a healthcare provider?
   ☐ **YES** ☐ **NO**
8. Do you currently, or did you in the last five years, engaged in the unlawful use of drugs, including the improper use of prescription drugs?
   ☐ **YES** ☐ **NO**
9. Do you have any felony or misdemeanor charges pending against you, other than a traffic violation, or have you ever been convicted or pleaded "nolo contendere" to a felony?
   ☐ **YES** ☐ **NO**
10. Have you been involved, within the last ten years, or are you currently involved in ANY claims/lawsuits, settlements, or judgments (other than divorce or custody)? If YES, please provide detailed information on a separate sheet of paper including: docket # of the case, location of the court, the names of the party plaintiff(s) and defendant(s), description and date(s) of the incidents(s), your involvement, current disposition, and the amount of settlement.
    ☐ **YES** ☐ **NO**
11. Are you currently practicing WITHOUT, or with and EXPIRED, Professional Liability/Malpractice Insurance?
    ☐ **YES** ☐ **NO**
12. Have you ever been reported to the National Practitioner's Data Base?
    ☐ **YES** ☐ **NO**

I hereby make formal application for network participation with **LIBERTY Dental Plan.**

***DOCTOR'S SIGNATURE:** _____ ***DATE:** ____/____/____
(No Signature Stamps)

***PRINT NAME:** _____ ***LICENSE #:** _____ ***STATE:** _____

Information Release / Acknowledgments:

I authorize **VerifPoint/CreDENTIALs** or any **LIBERTY Dental Plan contracted ("CVO")**, to consult with professional liability carriers and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics and other qualifications.

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (under "Credentialing Information") by and between LIBERTY Dental Plan and other Healthcare Organizations (e.g. hospital medical staff, medical groups, independent practice associations (IPA's), health plans, health maintenance organizations (HMO's), preferred provider organizations (PPO's), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, businesses and individuals acting as their agents (collectively, "HealthCare Organizations), for the purpose of evaluating this application and re-credentialing application regarding my professional training, experience, character, conduct, judgment, ethics, records and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patients' records and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluation the qualifications of healthcare providers. I hereby release all persons and entities, including LIBERTY Dental Plan and its agent(s), engaged in quality assessment, peer review and credentialing on behalf of LIBERTY Dental Plan, from an liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation with LIBERTY Dental Plan, to the extent that those acts and/or communications are protected by state and federal law.

I, the undersigned, hereby certify that the information requested by the CVO is truthful, correct and complete in all respects and I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating provider with the affiliated organization contracted with the CVO. The undersigned hereby agrees to notify the CVO of any changes in the above information.

I understand that if LIBERTY Dental Plan denies my application or otherwise takes action that is adverse to my request for participation, LIBERTY Dental Plan and/or its Representatives may be obligated, under applicable law, to report such action to the National Practitioner Data Bank and/or other licensing or accreditation agencies.

***DOCTOR'S SIGNATURE:** _____ ***DATE:** ____/____/____

(No Signature Stamps)

***PRINT NAME:** _____

ADDENDUM TO LIBERTY DENTAL PLAN PARTICIPATING PROVIDER APPLICATION

NOTICE OF PROVIDER CREDENTIALING RIGHTS

I. Right of Review

As an applicant for credentialing/re-credentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Dental Boards, and the National Practitioner Data Bank. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure.

You may request to review such information at any time by sending a written request via fax or letter to the Credentialing Department, P.O. Box 26110 Santa Ana, CA 92799-6110, fax number 800-268-0154. Following receipt of your request, you will be contacted by the Credentialing Department, within five (5) business days.

II. Notification of Discrepancy

You will be notified in writing, by fax or letter, when information obtained during primary source verification differs from information submitted on the application.

III. Correction of Erroneous Information

If you believe that erroneous information has been supplied to LIBERTY you may correct such information by submitting written notification to the Credentialing Department at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to the address above within fifteen (15) business days.

Upon receipt of your notification, LIBERTY will re-verify the primary source information. If the primary source information has changed, an immediate correction will be made to your credentialing file. If the primary source information remains inconsistent you will be advised of through a letter, fax, or phone call. If proof of correction is required then you must notify the credentialing department within ten (10) business days.

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

New Jersey Long Term Care Facility, Skilled Nursing Facility, & Dental Mobile Survey

Please complete the following information for *each* participating provider who treats your members who reside in a Residential Long Term Care Facility. Thank you for your assistance.

Name:		
Address:		
City:	State:	Zip:
Business Phone Number:		

Providers in Long Term Care Facilities

In which NJ counties does practice see patients? _____

How many dentists in the group treat patients in Long Term Care Facilities? _____

Do any hygienists employed by the practice work in Long Term Care Facilities? ☐ Yes ☐ No
If yes, how many? _____

Do they use a mobile van? ☐ Yes ☐ No

Is practice linked to "brick and mortar" facility (this does not include a billing office)? ☐ Yes ☐ No

Do they have referral relationship with practice(s) in close proximity to all facilities they serve? ☐ Yes ☐ No

Is practice accepting new facilities? ☐ Yes ☐ No

Is practice accepting new patients at all facilities they serve? ☐ Yes ☐ No

Mobile Dental Practice (Portable Equipment)

Please provide a list of the LTC, SNF, other sites or areas they serve. _____

_____

Indicate whether they provide comprehensive and emergency care. ☐ Yes ☐ No

Indicate if they make referrals when necessary for continuity of care. ☐ Yes ☐ No

When treatment is provided at a Long Term Care Facility or a Skilled Nursing Facility are duplicate records maintained at the facility? ☐ Yes ☐ No

Mobile Dental Van (Specially Equipped Vehicle)

Please provide a list of the LTC, SNF, Schools or other sites or areas they serve. _____

_____

Indicate if they are associated with a brick and mortar practice (not a billing office). _____

_____

Does the brick and mortar practice serve as a dental home providing comprehensive and emergency services?	☐ Yes ☐ No
Referrals to Specialists?	☐ Yes ☐ No
Is the brick and mortar practice located within the geographic access limitations as defined by 4.8.8 of the MCO Contract? This is determined by each site serviced.	☐ Yes ☐ No
Are dental records stored at the brick and mortar practice?	☐ Yes ☐ No
Do they participate in health fairs or one-time events?	☐ Yes ☐ No

B.7.35 Disclosure Statement Of Ownership And Control Interest, Related Business Transactions And Persons Convicted Of A Crime.

This form shall be submitted to the DMAHS annually and upon request. For definitions, procedures and requirements refer to 42 CFR 455.100-106 (copy attached).

Attach Separate Sheets

I. Identifying Information of Disclosing Entity (HMO)

Name of Disclosing Entity (HMO) and D/B/A:				
Street Address:	City:	County:	State:	Zip Code:
Telephone No:		Medicaid Provider No:		

II. Ownership and Control Interest

A. Please list the information required by subsections 7.35.A.1 and 2 of the Contract:

1.

Name:	Relationship:	
	Percent of Ownership:	
Primary Address:	Date of Birth: *(For Individuals)*	
	SSN: *(For Individuals)*	
PO Box Address: *(For Corporations)*		
IRS ID/Other Tax ID: *(For Corporations)*		
All business location addresses: *(For Corporations)*		
Relationship to other persons with ownership or control interest as required by 7.35.A.2. List all.		

2.

Name:	Relationship:	
	Percent of Ownership:	
Primary Address:	Date of Birth: *(For Individuals)*	
	SSN: *(For Individuals)*	
PO Box Address: *(For Corporations)*		
IRS ID/Other Tax ID: *(For Corporations)*		

All business location addresses: *(For Corporations)*
Relationship to other persons with ownership or control interest as required by 7.35.A.2. List all.

3.

Name:	Relationship:	
	Percent of Ownership:	
Primary Address:	Date of Birth: *(For Individuals)*	
	SSN: *(For Individuals)*	
PO Box Address: *(For Corporations)*		
IRS ID/Other Tax ID: *(For Corporations)*		
All business location addresses: *(For Corporations)*		
Relationship to other persons with ownership or control interest as required by 7.35.A.2. List all.		

B. Please list the information required by subsection 7.35.A.3 of the Contract:

Name	**Address**	**Relationship**

C. Please list the information required by subsection 7.35.A.4 of the Contract:

1.	Name:	
	Address:	
	Date of Birth:	SSN:

2.	Name:	
	Address:	
	Date of Birth:	SSN:

3.	Name:	
	Address:	
	Date of Birth:	SSN:

III. Disclosure by Contractor: Information related to business transactions.

Provide ownership information of
(1) Any subcontractor with whom the Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

Name	Address	Ownership

Disclose information on types of transactions with a "party in interest" as defined in Section 1318(b) of the Public Health Service Act (Section 1903(m)(4)(A) of the Social Security Act).

Name of party in interest	Description of Transaction	Accrued $ Value	Justification

IV. Disclosure of Information on persons convicted of crimes.

Identity of any person who has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services program since the inception of those programs.

Are there any directors, officers, agents, or managing employees of the Contractor who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, XX or XXI?

Yes ___ No ___ **If yes, list names and addresses of individuals or corporations.**

Name	Address	DOB and SSN, or TIN

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this Disclosure Statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the state agency or the secretary, as appropriate.

Name of Authorized Representative (Typed), Title and HMO

Signature **Date**

REMARKS:

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

Electronic Fund Transfer (EFT) Form

(Please Print Clearly)

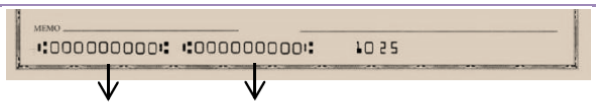
FACILITY INFORMATION

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.

By signing below, 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.

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

Amerigroup RealSolutions in healthcare

Division of Developmental Disabilities and Aged, Blind and Disabled Form

The State of New Jersey will begin to transition Medicaid enrollees with developmental disabilities and certain mental health problems into the Medicaid managed care program. Amerigroup Community Care is working to determine if the health care needs of these populations can be met by our current provider network. We ask you to please respond to the following questions.

Please include any experience with your aged, blind or deaf disabled patients. Qualifications can include years of providing care for these patients even if no formal training was undertaken in the past.

1. Do you feel qualified to handle patients (either children or adults) with developmental disabilities? (Circle) YES or NO

2. Do you feel qualified to handle patients with mental health/behavioral or substance abuse problems? (Circle) YES or NO

3. Do you feel qualified to handle patients with HIV and/or AIDS?
   (Circle) YES or NO

4. Do you feel qualified to handle the geriatric population (aged)?
   (Circle) YES or NO

If yes to the above questions, PLEASE BRIEFLY OUTLINE your qualifications including specialized training/certifications and experience.

_____

_____

_____

_____

_____ _____

Signature Date

Amerigroup RealSolutions in healthcare

AMERICANS WITH DISABILITIES ACT (ADA) PROVIDER SURVEY

PROVIDER NAME:_____ GROUP NAME:_____

ADDRESS: _____ OFFICE PHONE:_____

_____ OFFICE FAX:_____

*Complete a separate survey form for each office location or attach a copy on group letterhead stating each physician's name and practice addresses.

*If you have already completed an ADA Provider Survey Form previously for another healthcare company, please send a copy of this already completed survey.

Part I.

1. Number of staff members (include all medical professionals, members or partners of the professional association, technicians and support staff) employed at this office:_____
2. Year when the building in which provider's office is located was constructed:_____
3. Floor(s) of building on which provider's office is located:_____

Please answer the following questions regarding architectural accessibility to the provider's office:

4. Is handicap parking available? ☐YES ☐NO
5. Is the path of travel from the parking lot to the entrance of the building in which the provider's office is located barrier-free? ☐YES ☐NO
6. Is there street-level access or an accessible ramp into the building in which the provider's office is located? ☐YES ☐NO
7. If the provider's office is not on the first floor, is the office served by a working elevator which is accessible by wheelchair and motorized scooter? ☐YES ☐NO
8. Are the provider's office & other patient areas accessible by wheelchair and motorized scooter? ☐YES ☐NO
9. Are the examination rooms accessible by wheelchair and motorized scooters? ☐YES ☐NO
10. Are the office's restrooms accessible by wheelchair and motorized scooter? ☐YES ☐NO

Amerigroup RealSolutions in healthcare

**If you answered "yes" to every question 4 through 10 above, please skip the remaining questions and sign the attached certification.

If you answered "no" to any questions 4 through 10, and:

1. The building in which the provider's office is located was built **before January 1992 and structural alterations were made to the building after January 1992**, please answer the questions in Part II and sign the attached certification:

2. The building in which the provider's office is located was build **before January 1992, no alterations were made after that date and 15 or more staff are employed** at the provider's office, please answer questions in Part III and sign the attached certification, or

3. The building in which the provider's office is located was **built before January 1992, no alterations were made to it after that date and fewer than 15 staff are employed** at the provider's office, please answer the questions in **Part IV** and sign the attached certification.

Part II. **Building constructed before January 1992 with structural alterations made to building after that date:**

1. What alterations were made to the building? _____
   _____
   _____

2. Iff the altered portions of the building affected the usability of the facility, are the altered portions of the office readily accessible to and usable by mobility-impared and disabled individuals? ☐YES ☐NO

3. If the answer to question 2 is "no", explain:_____
   _____
   _____

Part III. **Building constructed before January 19920no alterations made to the building after that date – provider has 15 or more staff employed at that location:**

1. Does the provider or group have an alternate accessible location where services can be provided to mobility impaired or disabled individuals? ☐YES ☐NO

2. If the answer to question 1 is "yes", please describe the facility, including its location and distance from the provider's office:_____
   _____
   _____
   _____

3. If the answer to question 1 is "no", will the provider accommodate mobility impaired and disabled individuals through home visits? ☐YES ☐NO

Part IV. **Building constructed before January 1992 - no alterations made to building after, that date- provider has fewer than 15 staff employed at that location:**

If you determine after conferring with a mobility-impaired or disabled individual, that you are unable to see the individual in your office without making significant architectural alterations to the building or office, are you, the provider, willing to see the patient at a mutually acceptable and appropriate accessible location?

☐YES ☐NO

THE INDIVIDUAL COMPLETING THIS FORM MUST SIGN THE ATTACHED CERTIFICATION

CERTIFICATION OF ADA COMPLIANCE

I hereby certify that I have reviewed the Americans with Disabilities Act (ADA) , requirements which are set out on the attached sheet, that I have answered the above questions truthfully and to the best of my knowledge and that this (office/group practice) as well as the building in which it is located, meets the requirements of the ADA

_____ _____

Provider Name Provider Group Name

_____ _____

Signature of Provider or Authorized Practice Designee Date