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)

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.

Americans with Disabilities Act (ADA) Attestation

From (Practice Name): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Instructions: Please answer each question and sub-question by filling in the appropriate circle. Then mail the completed attestation and any related documentation to:

LIBERTY Dental Plan
Attn: Professional Relations
PO Box 26110
Santa Ana, CA 92799-6110
Fax: 800-268-0154

If you are completing this form on behalf of a practice, please attach a listing of dentists at your office. If your practice has more than one location, please complete a form for each location and attach a listing of dentists for each location. Once submitted, please notify LIBERTY Dental Plan within 10 business days of any change to your answers below. Additional forms can be downloaded from the "Join Our Networks" page at https://www.libertydentalplan.com/Providers/Join-Our-Network.aspx.

1.	Does the office have at least one wheelchair-accessible path from an entrance to an exam room?	☐ Yes	☐ No	
2.	Are examination tables and all equipment accessible to people with disabilities?	☐ Yes	☐ No	
3.	If parking is provided, are there spaces reserved for people with disabilities and pedestrian ramps at sidewalks and drop-offs?	☐ Yes	☐ No	
4.	If parking is provided, are there an adequate number (see below) of accessible parking spaces (8 feet wide for a car and 5-foot access aisle)?			
	Total spaces / **Accessible spaces** 1-25 / 1 26-50 / 2 51-75 / 3 76-100 / 4	☐ Yes	☐ No	
5.	a. For a provider with a disability-accessible parking space, is there a path of travel from the disability-accessible parking space to the facility entrance that does not require the use of stairs? b. Is the path of travel stable, firm and slip resistant? c. Except for curb cuts, is the path at least 36 inches wide?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No	 ☐ N/A ☐ N/A
6.	a. Is there a method for persons using wheelchairs or requiring other mobility assistance to enter as freely as everyone else? b. Is that route of travel safe and accessible for everyone, including people with disabilities?	☐ Yes ☐ Yes	☐ No ☐ No	 ☐ N/A
7.	Does the main exterior entrance door used by persons with mobility disabilities to access public spaces meet the following: a. 32 inches clear opening. b. 18 inches of clear wall space on the pull side of the door, next to the handle. c. The threshold edge is no greater than ¼-inch high; if beveled, no greater than ¾-inches high. d. The door handle is no higher than 48-inches high and can be operated with a closed fist.	 ☐ Yes ☐ Yes ☐ Yes ☐ Yes	 ☐ No ☐ No ☐ No ☐ No	

(Continued)

8.	a. Are there ramps to permit access? If yes, complete the following four questions: b. Are the slopes of the ramp accessible for wheelchair access? c. Are the railings sturdy and high enough for wheelchair access? d. Is the width between railings wide enough to accommodate a wheelchair? e. Are the ramps nonslip and free from any obstruction (cracks)?	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No ☐ No
9.	If there are stairs at the main entrance, is there also a ramp or lift or is there an alternative accessible entrance?	☐ Yes	☐ No
10.	Do any inaccessible entrances have signs indicating the location of the nearest accessible entrance?	☐ Yes	☐ No
11.	Can the accessible entrance be used independently and without assistance?	☐ Yes	☐ No
12.	Are doormats ½-inch high or less with beveled or secured edges?	☐ Yes	☐ No
13.	Are waiting rooms and exam rooms accessible to people with disabilities?	☐ Yes	☐ No
14.	Does the layout of the interior of the building allow people with disabilities to obtain materials and services without assistance?	☐ Yes	☐ No
15.	Do the interior doors comply with the criteria set forth for exterior doors (see question 7)?	☐ Yes	☐ No
16.	Are the accessible routes to all public spaces in the facility 31-inches wide?	☐ Yes	☐ No
17.	Is there a 5-foot circle or a T-shaped space for a disabled person using a wheelchair to reverse direction in public areas where services are rendered?	☐ Yes	☐ No
18.	Are all buttons or other controls in the hallway no higher than 42 inches?	☐ Yes	☐ No
19.	Do elevators in the facility meet the following standards: a. There are raised and Braille signs on both door jambs on every floor. b. The controls inside the cab have raised and Braille lettering. c. The call buttons in the hallway are not higher than 42 inches.	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
20.	Are sign language interpreters and other auxiliary aids and services provided in appropriate circumstances?	☐ Yes	☐ No
21.	Is the public lavatory wheelchair-accessible?	☐ Yes	☐ No
22.	With respect to the public restroom, do the accessible route, the exterior door and the interior stall doors comply with standards set forth for exterior doors (see question 7)?	☐ Yes	☐ No
23.	Is there at least one wheelchair-accessible stall in the public restroom that has an area of at least 5 feet by 5 feet clear of the door swing or is there at least one stall that is less accessible but provides greater access than a typical stall (either 36 by 69 inches or 48 by 69 inches)?	☐ Yes	☐ No
24.	In the accessible stall of the public restroom, are there grab bars behind and on the side wall nearest the toilet?	☐ Yes	☐ No
25.	Is there one lavatory in the public restroom that meets the following standards: a. 30-inches wide by 48 inches; deep bar space in front. b. A maximum of 19 inches of the required depth may be under the lavatory. c. The lavatory rim is no higher than 34 inches. d. There are at least 29 inches from the floor to the bottom of the lavatory apron. e. The faucet can be operated with a closed fist. f. The soap dispenser and hand dryers are within reach and usable with one closed fist. g. The mirror is mounted with the bottom edge of the reflecting surface 40 inches from the floor or lower.	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No

I hereby attest that I am a provider that occupies a physical site at which participants might possibly be physically present and that the answers provided are accurate. Or, I do hereby attest that I hold the authority to make these attestations.

Name	Date
Signature	

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:** _____

MAILING ADDRESS**:** _____

(if different from above) *Street Address* *Suite/Unit #*

_____

City *State* *ZIP Code*

LANGUAGES SPOKEN: _____

RECALL METHOD USED: _____

PRIMARY DENTIST: _____ ☐**DDS** ☐ **DMD** ☐**Other (specify)** _____

ASSOCIATE DENTIST: _____ ☐**DDS** ☐ **DMD** ☐**Other (specify)** _____

ASSOCIATE DENTIST: _____ ☐**DDS** ☐ **DMD** ☐**Other (specify)** _____

ASSOCIATE DENTIST: _____ ☐**DDS** ☐ **DMD** ☐**Other (specify)** _____

(Attach list with additional Associates if necessary)

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

☐**(FQHC)** Federally Qualified Health Center

☐**(CHC)** Community Health Center

☐**(IHS)** Indian Health Services

☐**(RHC)** Rural Health Clinic

Accessibility

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

What type of emergency contact system is used? _____

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

Age range of patients seen? ☐ **0 – 99+** ☐ **0 – 21** **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**

Re: LIBERTY Dental Plan Provider Network Request to Complete FIDA Training

Dear Doctor:

We are notifying you about a new Federal requirement for providers who treat Fully Integrated Duals Advantage (FIDA) participants in the state of New York.

Dentists are required to take a provider training through the Resources for Integrated Care website, which is administered by the Lewin Group and located at https://fida.resourcesforintegratedcare.com/my.policy. Dentists may also complete the training offline and submit a spreadsheet attesting to the individuals who completed the training. Instructions for this off-platform training are located at: https://www.resourcesforintegratedcare.com/FIDA_Downloadable_Provider_Training.

There are five required **training modules which are posted to the FIDA training portal from the web link appended above**. These courses are as follows:

- FIDA Provider Overview
- Behavioral Health
- Cultural Competency
- Disability Awareness
- Recovery and Wellness

LIBERTY Dental plan has additional information posted on our website to assist dentists at https://www.libertydentalplan.com/Resources/Documents/Provider%20Training.pdf. This information is also available on the FIDA Training Portal homepage for your convenience and reference at any time.

Thank you in advance for your ongoing service to ensure that quality care is delivered to FIDA participants. If you have any questions regarding this correspondence, please contact Salvatore Mongelli at (888) 352-7924 x478 or Bruce Waugaman at (888) 352-7924 x5181.

Sincerely,

LIBERTY Dental Plan
Professional Relations

DENTAL PLAN | PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT (the "Agreement") is made and entered into by and between **LIBERTY Dental New York, LLC** ("LIBERTY") and [LEGAL NAME OF DENTAL OFFICE]: _____("Dental Office"), a [CHECK ONE]: □ *individual practice* □ *partnership* □ *professional corporation* □ *other*:_____, effective as of the date specified by LIBERTY on the signature page (the "Effective Date"). LIBERTY and Dental Office may each be referred to as a "Party" and together, may be referred to as the "Parties."

RECITALS

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

ARTICLE II: OBLIGATIONS OF DENTAL OFFICE

2.1 Provision of Services. Dental Office agrees to:

(a) Participate in the Dental Plan(s), as provided by LIBERTY and in accordance with applicable fee schedules, and provide the applicable Covered Services to all Members selecting Dental Office. Dental Office acknowledges and agrees that LIBERTY may delete, add to, or otherwise amend or modify 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.

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

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

2.2 Refusal of Services; Non-discrimination. Dental Office agrees to render all necessary dental services to each Member during Dental Office's regular office hours, subject to prior appointments; provided, however, that Dental Office shall have the right to refuse services to any Member who habitually has broken appointments or has behaved in a grossly discourteous manner toward Dental Office, Dental Office Agents and/or other patients. In order to ensure continuity of care, Dental Office shall immediately report to LIBERTY all such instances where Dental Office refuses services to a Member. Dental Office shall not discriminate in the treatment of Members or in the quality of services delivered to Members on the basis of race, sex, sexual orientation, age, religion, place of residence, health status, membership in a Dental Plan or program, national origin, disability, 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 York State Department of Health (SDOH) or SID guidelines or policies and (b) has provided to the Dental Office at least thirty (30) days in advance of implementation. 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.

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

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

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

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

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

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

2.4 Confidentiality.

(a) *Member Information.* Dental Office shall safeguard Members' privacy and confidentiality, assure accuracy of Members' health records and maintain records of Members in an accurate and timely manner. Dental Office agrees to comply with all state and federal laws, rules and regulations or applicable program requirements regarding the privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information, including without limitation the Health Insurance Portability and Accountability Act and any rules and regulations promulgated thereunder (collectively, "HIPAA"), as well as the Health Information Technology for Economic and Clinical Health Act and any rules and regulations promulgated thereunder (collectively, "HITECH Act"). Dental Office also agrees to release such information only in accordance with applicable state and federal laws or pursuant to court orders by a court of competent jurisdiction or validly issued subpoenas. . 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 the New York State Department of Health, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, and the New York State Attorney General, 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) six (6) years after the date of service; or (iii) in the case of a minor, the later of three (3) years after such minor reaches majority or six (6) years after the date of service.

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

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

year of this Agreement or upon LIBERTY's request and shall further notify LIBERTY immediately of any and all substantial changes in or cancellation of said insurance coverage. The failure of 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).

2.11 Fraud and Abuse Warning. In accordance with NY Insurance Law § 403(d), Dental Office shall use only those claim forms which include the following fraud warning be placed: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

ARTICLE III: QUALITY ASSURANCE

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

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

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

ARTICLE IV: COMPENSATION

4.1 Fees. In exchange for the provision of Covered Services to Members, 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.

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

ARTICLE V: TERM AND TERMINATION

5.1 Term. This Agreement shall continue in effect for one (1) year from the Effective Date (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 upon written notice provided to the other Party at least sixty (60) days prior to the end of the Term or Renewal Term. Any such non-renewal shall not constitute a termination for purposes of this Section 5.2.

(c) *By LIBERTY.* LIBERTY may deactivate Dental Office from further Member selection if LIBERTY determines that it needs to do so to investigate Dental Office's compliance with Agreement terms or with applicable laws or program rules, though LIBERTY is not obligated to do so. 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 there is imminent harm to patient care, (ii) there has been a determination of 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. LIBERTY also has the right to, in its sole discretion, terminate the Agreement with respect to the participation of only a particular dentist or dentists of Dental Office in the event of any of the foregoing occurrences as they involve such dentist(s).

ii. Termination upon notice. LIBERTY may also terminate this Agreement upon at least sixty (60) days' written notice to Dental Office, which notice shall provide the reason(s) for the proposed action and shall specify the time limit (of not less than thirty (30) days) within which Dental office may request a hearing.

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 immediately.

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

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

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

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 York, 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 York County, New York, 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 and/or administrative guidelines, and all applicable attachments, exhibits, addenda and fee schedules) is the final expression of, and contains the entire agreement between, the Parties with respect to the subject matter hereof and supersedes all prior communications or understandings with respect thereto.

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

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

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

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

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

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

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

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

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

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

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

To LIBERTY:
LIBERTY Dental New York, LLC
Attn: Professional Relations
340 Commerce, Suite 100
Irvine, CA 92602

To Dental Office:
Address specified on signature page

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

("DENTAL OFFICE"):

Authorized Signature

Print Name of Signatory

Title

Date

Dental Office Name

Dental Office Address

City, State ZIP

Primary Dentist License #

SS# and/or Tax ID#

Individual National Provider Identifier (NPI)

Organizational National Provider Identifier (NPI) *(if applicable)*

LIBERTY Dental New York, LLC ("LIBERTY"):

Signature

Print Name of Signatory

Title

Effective Date

LIBERTY Dental Plan

PROVIDER AUTHORIZED SIGNATORY FORM

"Dental Office": _____
Dental Office Name

_____
Dental Office Address

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

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 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***

NEW YORK MEDICAID ADDENDUM

This NEW YORK MEDICAID ADDENDUM (the "Addendum") to the Provider Agreement (the "Agreement") entered into by and between LIBERTY Dental New York, LLC (collectively with any affiliates, subsidiaries and parent corporations, "LIBERTY") and the legal entity or individual qualified and licensed to practiced dentistry in the state of New York as defined in the Agreement and as specified on the signature page of this Addendum ("Dental Office") is meant to supplement the Agreement. LIBERTY and Dental Office 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. Dental Office acknowledges that the following provisions are required for participation in New York Medicaid managed care and Family Health Plus/Child Health Plus programs (collectively, the "Programs"); accordingly, should this Addendum expire or terminate, Dental Office shall not be permitted by LIBERTY to participate in the Programs. Specific Medicaid managed care terms set forth below shall apply if, and only to the extent, Dental Office is participating in Medicaid managed care; similarly, Family Health Plus/Child Health Plus terms set forth below shall apply if, and only to the extent, Dental Office is participating in such programs. LIBERTY and Dental Office hereby agree as follows:

1. *Program Performance Standards.* Dental Office 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") and/or Family Health Plus/Child Health Plus contract (the "FHP/CHP Contract"). LIBERTY shall monitor the performance of Dental Office and shall terminate this Addendum and/or impose other sanctions if Dental Office's performance does not satisfy standards set forth in the Medicaid Contract and/or the FHP/CHP Contract. In addition, if Dental Office's performance does not meet such standards or LIBERTY identifies deficiencies or areas of needed improvement in Dental Office's performance, Dental Office shall take corrective action.

2. *Confidentiality.* Dental Office shall comply with all confidentiality requirements set forth in the Medicaid Contract and/or FHP/CHP Contract.

3. *LIBERTY Actions.* With respect to Dental Office's participation in the Programs, LIBERTY shall not impose obligations and duties on Dental Office that are inconsistent with the Medicaid Contract and/or FHP/CHP Contract, or that impair any rights accorded to the New York State Department of Health (SDOH), the local Department of Social Services, or the United States Department of Health and Human Services (DHSS).

4. *Access to Records.* The DHHS shall have access to Dental Office's medical/dental records, encounter data and financial information.

5. *Use of Federal Funds.* Dental Office 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 and FHP/CHP Contract.

6. *Disclosures.* Dental Office shall disclose to LIBERTY complete ownership, control and relationship information. In addition, Dental Office 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. Dental Office shall monitor employees and staff against the "List of Excluded Individuals and Entities" (LEIE) and excluded individuals posted by the New York State Office of the Medicaid Inspector General (OMIG) on its Website. LIBERTY is required, within thirty-five (35) days of a request by SDOH, OMIG 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, Dental Office agrees to assist LIBERTY in complying with any such request.

7. *Member and SDOH Non-liability.* Dental Office agrees that in no event, including, but not limited to, nonpayment by LIBERTY, insolvency of LIBERTY, or breach of this Agreement, shall Dental Office 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 or FHP/CHP Contract and the Agreement. In addition, in the case of Medicaid managed care, Dental Office agrees that, during the time of Member's enrollment/membership, Dental Office will not bill SDOH or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the agreement between the managed care organization and the SDOH. And in the case of Family Health Plus, Dental Office agrees that, during the Member's enrollment/membership, Dental Office will not bill SDOH for Covered Services within the Family Health Plus Benefit Package, as set forth in the agreement between the applicable

managed care organization and the SDOH. This provision shall not prohibit Dental Office, unless the applicable managed care organization is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), 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 Dental Office shall have advised the Member in writing prior to providing the service that the service is uncovered and of his/her liability therefore.

8. *Coordination of Benefits.* With respect to Members eligible for medical assistance or participating in Family Health Plus or Child Health Plus, Dental Office shall maintain and make available to LIBERTY records that reflect coordination of benefits proceeds collected by Dental Office 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.

9. *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 Dental Office is providing services to Members under the Programs, LIBERTY retains the option to immediately terminate the Agreement if, and when, Dental Office has been terminated or suspended from the Medicaid Program.

10. *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 applicable managed care organization and the SDOH or the New York City Department of Health and/or the FHP/CHP Contract between the applicable managed care organization and the SDOH or the New York City Department of Health 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 Dental Office'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.

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

("DENTAL OFFICE"):	**LIBERTY Dental New York, LLC ("LIBERTY"):**
Authorized Signature	Signature
Print Name	Print Name
Title	Title
Date	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.

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.

Electronic Fund Transfer (EFT) Form

(Please Print Clearly)

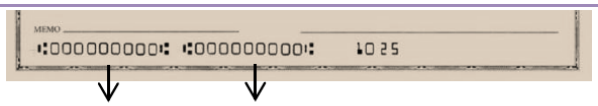
FACILITY INFORMATION

Type of Authorization: ☐ Add ☐ Update ☐ Cancel

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

ACCOUNT INFORMATION

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



Routing Number Account Number

One of the following must be attached:

☐ Voided Check

☐ Confirmation letter from your bank with required account information

AUTHORIZATION

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

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

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

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

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

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

Authorized Signature:	Date:
Print Name:	Title:

CANCELLATION

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

LIBERTY DENTAL PLAN USE ONLY

Vendor Name:	Vendor ID:

Electronic Fund Transfer (EFT) Form

(Please Print Clearly)

Instructions for Completing the Electronic Fund Transfer (EFT) Form

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

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

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

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

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

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

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

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

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

Mail submissions to:

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