Provider Membership/Credentialing Application

TDA
Total Dental Administrators

Plans Applying For:
☐ PPO ☐ DHMO ☐ Eclipse

PROVIDER INFORMATION

Last Name:	First Name:	MI:	DDS: ☐ DMD: ☐
Provider NPI Number:	Provider SSN:	DOB:	Gender: Male ☐ Female ☐
Dental School:		State:	Year:
Board Certified:* Yes: ☐ No: ☐	Name of Certifying Board:		
Specialty:	Name of Specialty Training Institution:	State:	Year:
State License #:*	License EXP:	DEA #:*	DEA EXP:
Malpractice Carrier:*	Malpractice Policy #:	Malpractice EXP:	Limits:	Medicaid #(if applicable):
Provider Email:	Languages Spoken:		

Five Year Work History - Chronological including current employer. Explain any gaps greater than six (6) months

Date From	Date To	Place

OFFICE INFORMATION

Office Name:			TIN (**W9 Required**):	Office NPI:
Office Street Address:				Office Manager:
City:	State:	Zip:	Website:	
Office Phone:	Office Fax:		Office Email:	
Office Hours: Monday:	Tuesday:	Wednesday:	Thursday:	Friday: Saturday Sunday:
Minimum Patient Age:	Maximum Patient Age:	In house lab? Yes: ☐ No: ☐	Handicap Accessible? Yes: ☐ No: ☐	

REQUIRED ITEMS:

☐ DEA Certificate ☐ W9 ☐ Signed Contract ☐ Signed Application ☐ License Copy ☐ Malpractice ☐ Specialist Cert (if applicable)

*Please include a copy

Internal Use Only:
SH _____
PRV _____

Return Address: Total Dental Administrators, Inc.
2800 N 44th St Suite 500
Phoenix, AZ 85008
Fax: 602.266.1948 Email: credentialing@tdadental.com

TDA
Total Dental Administrators

Provider Name:

OFFICE INFORMATION CONTINUED

Billing Address (If different from Office Address):		
Billing City:	Billing State:	Billing Zip:
Billing Phone:	Billing Fax:	Billing Email:

ADDITIONAL OFFICE INFORMATION

Office Name:			TIN (**W9 Required**):	Office NPI:	
Office Street Address:				Office Manager:	
City:	State:	Zip:	Website:		
Office Phone:	Office Fax:		Office Email:		
Office Hours: Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday Sunday:
Minimum Patient Age:	Maximum Patient Age:	In house lab?	Yes: ☐ No: ☐	Handicap Accessible? Yes: ☐ No: ☐	

Office Name:			TIN (**W9 Required**):	Office NPI:	
Office Street Address:				Office Manager:	
City:	State:	Zip:	Website:		
Office Phone:	Office Fax:		Office Email:		
Office Hours: Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday Sunday:
Minimum Patient Age:	Maximum Patient Age:	In house lab?	Yes: ☐ No: ☐	Handicap Accessible? Yes: ☐ No: ☐	

Office Name:			TIN (**W9 Required**):	Office NPI:	
Office Street Address:				Office Manager:	
City:	State:	Zip:	Website:		
Office Phone:	Office Fax:		Office Email:		
Office Hours: Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday Sunday:
Minimum Patient Age:	Maximum Patient Age:	In house lab?	Yes: ☐ No: ☐	Handicap Accessible? Yes: ☐ No: ☐	

TDA
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Provider Name:

ATTESTATION

1. Have you ever had any of the following items voluntarily or involuntarily denied, Revoked, suspended, terminated, not renewed, placed under probation, subjected to disciplinary action, sanctioned, or otherwise limed or curtailed:		
Dental License in any state within the past five years?	Yes: ☐	No: ☐
DEA certificate or other narcotic registration?	Yes: ☐	No: ☐
Hospital or other health care facility staff membership or privileges?	Yes: ☐	No: ☐
Professional organization membership	Yes: ☐	No: ☐
Medicare, Medicaid, or other government program participation	Yes: ☐	No: ☐
Dental or health plan participation	Yes: ☐	No: ☐
Board certification?	Yes: ☐	No: ☐
2. Have any items above been voluntarily relinquished or pending currently?	Yes: ☐	No: ☐
3. Has your professional liability insurance ever been denied, suspended, canceled or not renewed?	Yes: ☐	No: ☐
4. Have you ever been subject of a peer review?	Yes: ☐	No: ☐
5. Have you ever been employed as a dentist or other provider by a military service, hospital, HMO, or any other health care organization?	Yes: ☐	No: ☐
If so was your employment ever terminated by the employer?	Yes: ☐	No: ☐
6. Have you ever been subject to any findings (i.e., letters of guidance, censure admonition etc.) by a State Board of Dental Examiners?	Yes: ☐	No: ☐
7. Do you now have, or within the last five years had, any physical condition, mental condition, substance or chemical dependency condition that does or has interfered with your ability to practice dentistry with or without accommodation?	Yes: ☐	No: ☐
8. Are you now or have you within the last two years received treatment or been advised to receive treatment for alcohol or other substance or chemical dependency?	Yes: ☐	No: ☐
9. Have you ever been convicted of a crime (other than a traffic offense,) or are you currently under investigation or indictment for an alleged crime?	Yes: ☐	No: ☐
10. Has any malpractice claim, settlement, judgment, or arbitration ever been paid by you or paid on your behalf?	Yes: ☐	No: ☐
11. Do you have any pending malpractice, arbitration, or State Board issues?	Yes: ☐	No: ☐
12. Do you have any chronic communicable disease or other medical conditions that would pose a risk to the safety or well being of your patients?	Yes: ☐	No: ☐

13. Do you have any limitations for which reasonable accommodation is necessary in order to perform the essential and/or marginal duties of your job?	Yes: ☐	No: ☐
14. Has all clinical staff been vaccinated for Hepatitis B or signed a waiver?	No: ☐	Yes: ☐
15. Does your office meet all Federal and State requirements, including ADA, OSHA and CDC infection control recommendation guidelines?	No: ☐	Yes: ☐

Use a separate piece of paper to give details for any "yes" response(s) to questions 1-12.

I attest that the information contained in this application is correct and complete. From here forward the Plan and Total Dental Administrators, Inc. and their authorized credentialing agents or associates will be know as the Plan. I, the undersigned, agree and authorize the Plan to do all necessary investigation to determine the above information, specifically but not limited to, my professional qualifications. I also authorize the Plan to disclose necessary information about me directly pertaining to the above information. I release the Plan and everyone involved from any liability connected with the release of such information so long as the party(ies) involved was (were) acting in good faith without malice. The undersigned agrees to notify the Plan of any changes in the above information within 10 days. The undersigned further understands that the intentional submission of false or misleading information or the withholding of relevant information is grounds for immediate termination from the Plan.

Applicants Signature

Date:

MEMBER DENTIST AGREEMENT-GENERAL

This Agreement is made and entered into this____day of_____,20__ by and between _____(hereinafter referred to as DENTIST) who is duly qualified and licensed to practice DENTISTRY in the State of _____ and Total Dental Administrators of Utah, Inc., (hereinafter referred to as PLAN) whenever mentioned herein the term DENTIST shall include all employees of DENTIST, all partners, dental associates, and all staff and personnel under his and her direct control and /or supervision or as defined by the State Dental Practice Act(s).

WHEREAS, the PLAN was organized for the purpose of securing the benefits of dental service through the establishment of a managed dental care program for individuals or groups of individuals; and,

WHEREAS, the dentist is willing to join in and assist the PLAN in such a managed dental care program upon the basis hereinafter set forth, now therefore, in order to fix the rights and liabilities of the parties hereto under the Corporation's prepaid dental service plan.

Now, therefore, the parties do mutually covenant and agree as follows:

1. DEFINITIONS:

Dentist shall mean an individual who is licensed as a Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DMD), in accordance with applicable state law and who is practicing within the scope of such license, including any associates, hygienists and technicians recognized by the dental profession who act with and assist the DENTIST.

DEPENDENT shall mean the lawful spouse and children of a Member, if enrolled in a Plan.

MEMBER shall mean a person who is actually enrolled in a Plan.

ORGANIZATION shall mean the group or employer, which was entered into, or will enter into, a contract with the PLAN and to provide PLAN dental care benefits to its employees and other eligible participants.

2. RENDITION OF CARE:

DENTIST agrees to render all necessary dental services to each of the Members of any group covered by this Agreement, during his regular office hours, subject to prior appointments; provided, however, that DENTIST shall have the right within the framework of professional ethics to reject any patient seeking his professional services. Emergency care appointments will be rendered as soon as possible; all other appointments shall be given not more than three (3) weeks after the time requested by the MEMBER. The Dentist shall have, during the entire term it is servicing any MEMBER referred to it by PLAN, an adequate and effective recall system.

3. ELIGIBILITY:

The determination of the eligibility of any Member shall be made by the Organization and the PLAN, before DENTIST renders any dental services. The PLAN shall notify DENTIST whether such person is eligible and the nature and extent of benefits to which the MEMBER is entitled. The PLAN shall provide DENTIST with an eligibility list of Members updated monthly and other eligibility information as may be reported by the PLAN.

The PLAN shall not be liable to DENTIST for any services rendered to persons not determined as eligible for benefits. The PLAN has instituted specific procedures so that DENTIST may determine which persons are Members and has advised DENTIST of such procedures.

DENTIST agrees to accept all Members certified as being eligible by the PLAN. DENTIST may notify the PLAN that his or her office is closed to new Members upon ninety- (90) days prior written notice. Prior to the effective date of any such notice and during that ninety- (90) day notice period. DENTIST shall accept any and all new Members selecting DENTIST, and shall render all necessary care, treatment, and services to all Members, subject to the terms of the Contract.

4. SERVICES NOT COVERED- FEES DUE DIRECTLY FROM MEMBER:

It is specifically understood and agreed that cases will arise where DENTIST will perform dental services for Members or participating groups, which services are surcharged by the contract then in force between the Member and the group and/or the group and PLAN; or which, under such contract, are required to be paid for by the Member or his dependent personally in whole or part. In such cases, DENTIST agrees to look solely to the Member for payment for such services and payment of such services shall be billed by DENTIST, at a rate not to exceed the amount(s) set forth in the Fee Schedule attached. If such services are not listed on the Schedule attachment, then DENTIST shall charge not in excess of his usual and customary fee therefore.

5. BASIS OF PAYMENT TO DENTIST:

For all services provided by DENTIST to members of participating groups, other than those services which are collected directly by DENTIST from such members. DENTIST agrees that he/she will make no charge to the patient and will look exclusively to PLAN for periodic capitation payments or other such compensation as may be provided by the Plan. Such compensation shall be paid to him/her on the following basis:

Periodic payments along with Eligibility Lists are sent to the Dentist by the PLAN. Payments may be annually or monthly prepaid. The payment or capitation is based on the number of members selecting DENTIST's facility and the benefits to which member is entitled to receive.

6. SUBSTITUTE AND ACCESSIBILITY TO SERVICES:

The Facility shall be open for business consistent with the customary hours of the dental community. DENTIST shall notify PLAN of hours of operation and of any charges thereto. DENTIST shall not refuse to provide services to any member because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation or age. DENTIST shall be accessible and available to all Members in the same manner and to the same degree as DENTIST is to fee for service, insured or other patients, and shall not discriminate in any manner whatsoever in scheduling appointments for Member. Member will be directed by Plan to contact Member Dentist directly for the purpose of making appointments. In non-emergency cases, a reasonable waiting time for an appointment shall not exceed that which is customary in the local dental community. Any such customary standards shall be determined by PLAN through random survey of dental offices in the community.

DENTIST shall maintain 24-hour telephone service to handle emergency calls. Emergency patients shall be treated without delay no later than 24 hours from initial contact, seven day a week.

Whenever the dentist is on vacation or to be absent for any extended period, DENTIST shall provide a substitute dentist who shall be responsible for the care and treatment of Members.

7. STANDARDS OF DENTISTS CARE:

Dentist agrees that he/she shall perform his obligations under this Agreement in accordance with high standards of competence, care and concern for the welfare and needs of the members of participating groups and their dependents and in accordance with the principles of ethics of the American Dental Association and the Dental Practice Act of the State of _____. It is understood that the inclusion of DENTIST on the panel of each group is not a recommendation of DENTIST by the group or PLAN.

8. BENEFITS WITH COPAYMENT:

From time to time DENTIST may perform services for a Member which requires the payment of a copayment, as specified in the Member's benefit plan. DENTIST shall obtain all copayments directly from the Member, and not the PLAN or the Organization. DENTIST agrees that he/she will not charge the Member for any benefit with copayment, more than the applicable copayment specified in the Member's benefit plan.

9. SPECIALIST REFERRALS:

PLAN agrees to provide DENTIST with a listing of participating specialists, where available. The procedures for referrals to specialists by DENTIST are dependent upon the terms of the particular PLAN covering the Member to be referred. Under certain Dental Plans, prior approval from PLAN may be required. If a participating Specialist is not available, the Member will be fully responsible for any care rendered by a non-participating Specialist.

10. NON-EXCLUSIVE:

This Agreement is not exclusive in any respect, and PLAN, each participating group, the Members of such groups, are entitled to enter into similar contracts with other Dentist and DENTIST is free to enter into similar contracts with other parties, or with other groups not represented by PLAN, and to maintain his/her private practice.

11. TERM OF CONTRACT:

This Agreement shall continue in effect until terminated by either party, effective Ninety (90) Days after written notice of intention to terminate is sent by registered or certified mail. Such termination 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 herein. In the event of the termination of the Agreement, DENTIST shall complete all work started prior to the termination as follows: If an impression has been taken, DENTIST will complete a partial or denture. On every tooth upon which work has been started.

12. STANDARD OF DENTAL CARE:

DENTIST agrees to perform the obligations of the Agreement in accordance with high standards of competence, care, and concern for the welfare and needs of the Members and in accordance with the Principles of Ethics of the American Dental Association, the laws, the locally accepted practice, and PLAN and Quality Assurance policies. DENTIST shall in no way differentiate the days or time of the day when he renders professional care to Members of the PLAN or his/her own private patients. It is understood that the inclusion of DENTIST on its panel of dentists is not a recommendation of DENTIST by the PLAN or any Organization. DENTIST represents that all dentists, technicians, hygienists, and assistants, who act with assist DENTIST, are appropriately licensed under applicable state law.

13. DENTIST-PATIENT RELATIONSHIP:

DENTIST shall maintain the Dentist-Patient relationship with Members of participating groups and shall be solely responsible to the patient for dental advice and treatment. It is expressly agreed between the parties that DENTIST is an independent contractor and that neither the group nor PLAN shall have any dominion or control over the dentist's practice, the dentist-patient relationship, his/her personnel or facilities.

14. MALPRACTICE:

DENTIST agrees to carry Malpractice Insurance in an amount not less than $100,000 per person or $300,000 per incident. DENTIST will instruct Professional Liability Insurer to Notify PLAN of termination of such coverage within 10 days of policy termination. DENTIST authorizes the Professional Liability Insurer to disclose PLAN, upon written request by PLAN, policy information including but not limited to policy number, dollar coverage amount, term of coverage, and claim history.

15. HOLD HARMLESS:

DENTIST agrees to hold harmless, defend and indemnify the PLAN, and any Organization, its boards of directors, officers, employees, agents and /or administrators from and against all claims, suits, demands and actions that may arise out of any alleged malpractice or negligent act or omission to act, caused or alleged to have been caused by DENTIST or any of his/her agents, employees, consultants, associates, owners or partners in the performance or omission of any professional duty assumed by DENTIST hereunder.

16. ASSIGNABILITY OF CONTRACT:

This Contract, being intended to secure the personal services of DENTIST, shall not be assigned or transferred, or its duties delegated without the prior written consent of the PLAN.

17. INDEPENDENT CONTRACTOR:

DENTIST is an independent contractor. None of the provisions of the Agreement or any other representations of the parties is intended to create any relationship between PLAN and DENTIST other than that of separate independent contracting entities. Neither the parties hereto nor any of their respective representatives, employees

or agents shall be construed to be the representative, employee, employer or agent of the other.

18. LICENSE: STANDARD OF DENTAL CARE:

DENTIST represents and warrants that DENTIST and all other dentists, technicians, hygienists and assistants at the Facility are duly and appropriately licensed under applicable state law, and shall maintain such licenses in good standing throughout the term of this Agreement; that all equipment used in the rendering of dental services under this Agreement and required to be licensed or registered are so licensed or certified; and that DENTIST has the staff, personnel and facilities to provide dental services as described in this Agreement and the PLANS.

19. UTILIZATION AND QUALITY CONTROL:

PLAN will organize a Quality Assurance and Utilization Review process through which dental care can be monitored on a continuing basis. A Peer Review Committee comprised of dentists will review patient evaluation, diagnosis, treatment and follow-up care. This will be accomplished by the Committee's comparison of DENTIST's dental care with standardized norms and criteria. All information gathered, and discussions held in this process will be kept confidential amongst Plan employees, Dental Directors and Peer Review Committee and not for general release.

20. CLAIMS AGAINST MEMBERS:

DENTIST agrees that, whether or not there is any unresolved dispute for payment claimed by DENTIST, under no circumstances will DENTIST, his agents, employees, consultants, specialists, or representatives, whether or not employed directly or indirectly by DENTIST, make any charges or claims against a member directly for any services rendered or which it is intended by the Agreement that DENTIST will be compensated in the manner stated herein by PLAN, except for any charge which is, according to provisions of the Agreement, to be made directly to and be paid directly by the Member or his dependent.

21. CONFIDENTIAL INFORMATION:

DENTIST acknowledges that PLAN has invested substantial time, expertise and expenses in creating prepaid dental plan documentation including but not limited to:

Agreements, forms, contracts, promotional material, Groups and/or members information and other documents relating to the business operation of PLAN.

DENTIST agrees to the above written material is the property of PLAN and will be kept confidential and will be used by DENTIST only in connection with its dealings with PLAN and the Groups and Members thereof referred to DENTIST by PLAN.

PROVIDER covenants and agrees not to use or disclose the identity of Participants or TDA's name or goodwill, or any other confidential and/or trade secret information which PROVIDER has received or acquired as a result of this Agreement, nor solicit, divert, or assist any other person or entity in so soliciting or diverting any Subscriber or Participant to leave the program.

22. DENTAL RECORDS:

All dental records for each Member of the PLAN serviced by DENTIST shall be retained by DENTIST for a period of not less than five (5) years. DENTIST shall also make said dental records available for inspection by the PLAN and/or a representative of the State upon reasonable notice.

23. WAIVER:

The failure of either party to insist upon the strict performance of any covenant contained herein or the election of any remedy contained herein shall not be construed as a waiver or relinquishment for the future of such covenant or remedy. No waiver or any breach of the Contract shall be effective unless in writing.

24. GOVERNING LAW:

A. This Contract shall be governed by and construed in accordance with the laws of the state of _____.

IF SIGNING AS AN INDIVIDUAL:

By_____
(Dentist Signature)

_____
Dentist Name (please print)

Date_____

SSN# or TIN#_____

IF SIGNING ON BEHALF OF GROUP/CORPORATION:

By_____
(Authorized Signature)

_____
Name/Title of above (please print)

Date_____

_____
Name of Professional Association/Corporation/Group
(please print)

IRS Tax# _____

Please list other members of group:
(Attach additional page)

PLEASE SUPPLY THE FOLLOWING INFORMATION WHETHER INDIVIDUAL OR GROUP:

Name of Professional Liability Insurance _____

Policy # _____ Expiration Date _____ Coverage Amount $_____

ACCEPTANCE

By_____
Plan Officer

Date_____

Total Dental Administrators of Utah, Inc.
6985 Union Park Center #675
Salt Lake City, Utah 84047

EXHIBIT A

TOTAL DENTAL ADMINISTRATORS OF UTAH, INC.

SUPPLEMENTAL PAYMENTS FROM CAPITATED FUNDED POOL

When the General Dentist provides the following dental care services in accordance with the Schedule of Benefits and Co-payments and all other contractual provisions of the Member Dentist Agreement, the General Dentist shall receive the following supplemental payments, for the eligible procedures performed by said General Dentist, from the Plan, TDA, to the extent of the capitation funding of the pool.

Each twelve-month period commencing on January 1st and ending December 31st shall be reviewed by TDA's Underwriter and adjusted in accordance with Underwriter's recommendations. Any excess (margin) between Supplemental Payment Capitation Deposits to the Fund, during the defined twelve-month period, and the total of Supplemental Payments disbursed to General Dentist and Specialists from the fund plus the reserves established for the incurred member dentist encounters (encounters for services rendered during the twelve-month period but not yet received or processed by the Plan) shall be distributed to each participating dentist before March 31st of each year.

Disbursement of the fund margin to each participating dentist/specialist shall be based upon the percentage of the participating dentist's total supplemental payments received, during the defined twelve-month period, versus the total of all supplemental payments paid out of the fund to all general dentists and specialists. Dentists/Specialists must be active participating providers on December 31st to be eligible for any disbursement.

The following supplemental payments shall apply to the noted series of plans. Any new plans that may be issued, hereafter, shall include the applicable supplemental payments should it vary from the following table:

CODE	DESCRIPTION
D0150	Initial oral exam
D0120	Periodic oral exam (twice in any 12 consecutive months & includes Initial exam)
D0210	Intraoral- complete including bitewing x-rays (once in a 3 year period)**
D0272	Bitewing x-rays (two films)
D0274	Bitewing x-rays(once in a six(6)month period)
D0330	Panoramic film -includes bitewing x-rays (once in a 3 year period)**
D1110	Dental prophylaxis - Adult (routine cleaning only once in a 6 month period
D1120	Dental prophylaxis - Child (routine cleaning only once in a 6 month period
D1206	Fluoride treatment (limit 1/yr. To age 15)