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:

TOTAL DENTAL ADMINISTRATORS, INC.
PROVIDER AGREEMENT

6985 Union Park Center, Suite 675 SLC, UT 84047
(800) 880-3536 or (801) 268-9740

This agreement is entered into by and between Total Dental Administrators, Inc. (hereinafter "TDA") and _____(hereinafter referred to as "Provider")

I. DEFINITIONS

1. Participant: An individual who has enrolled in the TDA, Inc. PPO-Plan
2. Provider: An individual, partnership, professional corporation, their agents, or employees who are lawfully licensed under the laws of the State where the dental services are rendered and who shall provide professional dental services to Participants at their respective offices, under the terms of this Agreement.
3. **Dental Services:** Those professional dental services to eligible Participants under a dental program which accesses by Agreement with TDA, Inc. the TDA-PPO.
4. **Fee Schedule:** The schedule of procedures and applicable fees is attached hereto. Any procedures not listed may be covered and the applicable fees will be determined by TDA in the same manner used to establish the attached schedule of procedures and fees.

II. DUTIES AND OBLIGATIONS

1. PROVIDER agrees to accept the Fee Schedule for Dental Services by TDA, Inc. as payment in full for all Participants.
2. PROVIDER hereby agrees to provide professional dental services to Participants which shall be identical in all respects to those dental services rendered to non-participants.
3. PROVIDER shall provide all dental services, equipment, supplies, staff, billing and collection procedures necessary to provide the dental services to Participants.
4. PROVIDER agrees to defend, indemnify and hold TDA harmless from and against any claim, lawsuit, liability, damages, judgement and cost of litigation including attorney's fees arising out of such PROVIDER'S negligence, malpractice, errors or omissions in providing dental services and/or products, except to the extent that TDA's insurer provides insurance coverage of the act or omission complained of.
5. PROVIDER shall maintain a valid current policy of professional liability insurance acceptable to TDA and will supply TDA with a certificate of insurance. Further, PROVIDER agrees to immediately notify TDA with respect to any impending change, cancellation, or other modification of such insurance.
6. 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.
7. PROVIDER will complete dental treatment of a Participant in accordance with the terms hereof, or at the Participant's request transfer records and x-rays to another Provider in the event this Agreement is terminated.
8. PROVIDER will cooperate and participate in the Peer Review and Quality Assurance programs established by TDA.

III. DUTIES AND OBLIGATIONS OF TDA

1. TDA shall require all contracting carriers of TDA-PPO to issue to all Participants identification cards and initial service cards which will enable PROVIDERS to identify Participants enrolled in the PPO Plan. TDA agrees that PROVIDER shall have the right to require Participants to display such identification cards prior to performing dental services; and the right to contact Participant's Plan for eligibility and benefit verification.
2. TDA shall periodically publish and provide to Participants a listing of the name, address and area(s) of practice of PROVIDER.
3. TDA shall upon reasonable notice and at the Provider's office, review and photocopy records of such procedures which will allow TDA to effectively monitor compliance of Provider with the PPO Plan.
4. TDA agrees to defend, indemnify and hold PROVIDER harmless from and against any claim, lawsuit, liability, damages, judgement and cost of litigation including attorney's fees arising out of acts of TDA, except to the extent that PROVIDER'S insurer provides insurance

coverage of the act of omission complained of.

IV. TERMS OF AGREEMENT

1. This Agreement shall begin on the date designated below and shall remain in effect for one (1) year and be automatically renewed from year-to-year thereafter, subject however to cancellation by either party without cause upon the giving on ninety (90) days written notice to the other.
2. This Agreement shall also automatically terminate upon the violation of any of the terms of this agreement.

V. ASSIGNMENT

1. **Independent Contractor.** Nothing contained herein shall be constructed to create the relationship of employer/employee, partner, joint ventures or principal/agent between the parties hereto. PROVIDER shall be and remain an independent contractor, solely responsible for its employees and agents and TDA, Inc. Will not interfere or control, in any manner, the rendering of dental services by PROVIDER or his agents. PROVIDER will be solely responsible for the quality of treatment provided to Participants.
2. **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of Utah.
3. **Non-Exclusivity.** This agreement does not prevent provider from entering into similar PROVIDER agreements with other organizations which offer a program similar to the PPO-Plan.
4. **Separability.** Each provision of this Agreement shall be considered separable and, if for any reason, any provision shall be deemed invalid, void, unenforceable or contrary to any existing or future law, such invalidity shall not impair the operation of or affect those provisions of this Agreement which are valid.
5. **Amendment.** This Agreement may not be modified, amended or changed without the prior written consent of all parties hereto.
6. **Entire Agreement.** This Agreement, including the appendix and fee schedule, set forth all her representations, promises, agreements and understandings between the parties hereto. This Agreement may be executed in several counterparts, each of which shall be deemed to be an original copy of all which together shall constitute one agreement binding on all parties hereto.
7. **Notices.** All notices required or contemplated under this Agreement shall be in writing and shall be sent by certified mail, postage prepaid, addressed to the other party at the address on the signature page hereof.

IN WITNESS WHEREOF, The parties hereunto have affixed their signatures and seals on the day first above written.

PROVIDER:
Signature:_____
Date: _____
Name/ Address (please print):

_____
_____
_____

Phone #:_____
Specialty:_____
Tax I.D./Social Security#_____

TOTAL DENTAL ADMINISTRATORS, INC.
Signature:_____
Date: _____