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
Total Dental Administrators

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 OF UTAH, INC.
6985 S UNION PARK CENTER
SALT LAKE CITY, UT 84047
(801) 268-9740 or 1-800-880-3536

TOTAL CARE
SPECIALIST AGREEMENT

This agreement, including any and all attachments, is made and entered into this_____day of _____,20_____ by and between_____(hereinafter referred to as Specialist) who is duly qualified and licensed to practice as a(n) _____in the State of_____and Total Dental Administrators of Utah, Inc. (TDAUT), (herein referred to as PLAN) whenever mentioned herein. The term Specialist shall include all employees of Specialist, all partners, dental associates, and all staff and personnel under his/her direct control and/or supervision or as defined by the State Dental Practice Act(s).

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

I. DEFINITIONS:

A. Member shall mean a person who is actually enrolled in a dental plan and eligible to receive services as provided for herein through an Organization under contract with the Plan.
B. Dependent shall mean the lawful spouse and children of a Member, if enrolled in a Plan.
C. Specialist shall mean an individual who is licensed as on Oral Surgeon, Endodontist or Periodontist, 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 Specialist.
D. Dental Services shall mean those professional dental services noted in each TDA dental care program, contained in Attachment A of this Agreement, and applicable to each eligible participants.
E. Fee Schedule shall mean the maximum allowable fees to be charged for covered dental services.
F. 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.

II. SPECIALIST REFERRALS:

A. The PLAN agrees to provide participating general dentists with a listing of Participating Specialists. The procedures for referral to a Participating Specialist by general dentists are dependent upon the provisions of each particular Dental Plan covering the Member to be referred. Some TDA Dental Plans require an authorization code from the PLAN prior to patient referral. Specialist agrees to accept Members referred by general dentists as described below:

1. STANDARD PLAN REFERRALS: Programs not requiring prior Plan authorization. General dentists may refer patients to the Specialist without an authorization code. Member is responsible for Specialist's fee in accordance with the dental plan. The referring office (General Dentist) will be responsible for determining the eligibility of each patient referred.
2. PLAN AUTHORIZED REFERRALS: Some dental plans require prior authorization by the PLAN for a Specialist referral. The prior authorization process is designed to ensure Eligible Members are referred to Participating Specialists. Specialists must receive an authorization code from the PLAN (TDA) for Members to be eligible for dental care services, and for the Specialist to be compensated from the PLAN.

III. COMPENSATION:

A. Specialist agrees not to charge more than the specified fees and/or _____% of his/her fees, as filed with TDA on the date of this Agreement, and in accordance with the various TDA Dental Programs.

B. Standard Total Care Dental Plans: Specialist's office will be responsible for billing and collection from the patient the fees as set forth by the dental plan.

C. Prior Authorization plans: Specialist's office will be responsible for billing and collection from the patient and the Member's Total Care Dental Plan Schedule of Benefits and Copayments. Specialist's office will be responsible for submitting an encounter (with patient name, S.S. #, TDA's authorization code, eligible dental services rendered and dates) to PLAN (TCA) for balance of the total eligible fee.

D. Dual Payments: In the event a Covered Participant is also covered under a policy of insurance or other prepayment program which is considered primary and which provides benefits for services that are within the scope of care provided for in the Total Care Dental Plan, Specialist agrees that any payment which Specialist receives under such other policy or program shall be credited first to reduce any Patient Copayment obligation (this does not apply to TDA-PPO plans.)

E. Services Not Covered- Fees Due Directly From Member: Specialist agrees to look solely to the Member for payment of any dental services not set forth in the Total Care plan Schedule of Benefits and Co-Payments.

IV. TERM OF CONTRACT:

A. 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 of the Agreement, Specialist shall complete all work started prior to the termination as follows:

1. On every tooth upon which any restorative treatment has been started.

V. MALPRACTICE:

A. Specialist agrees to carry Malpractice Insurance in an amount not less than $100,000 per person or $300,000 per incident. Specialist will instruct Professional Liability Insurer to notify PLAN of Professional Liability Insurer to disclose to PLAN, upon written request by PLAN, policy information including but not limited to policy number, dollar coverage amount, term of coverage, and claim history.

VI. ASSIGNABILITY OF CONTRACT:

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

VII. CLAIMS AGAINST MEMBERS:

A. Specialist agrees that, whether or not there is any unresolved dispute of payment claimed by Specialist, under no circumstances will Specialist, his agents, employees, consultants or representatives, whether or not employed directly or indirectly by Specialist, make any charges or claims against a member directly for any services rendered or which it is intended by the Agreement that Specialist 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.

VIII. CONFIDENTIAL INFORMATION:

A. Specialist acknowledges that PLAN has invested substantial time, expertise, and expenses in creating 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.

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

IX. DENTAL RECORDS:

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

X. NON-EXCLUSIVE:

A. 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 Specialists and Specialist 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.

XI. HOLD HARMLESS:

A. Specialist 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 Specialist or any of his/her agents, employees, consultants, associates, owners or partners in the performance or omission of any professional duty assumed by Specialist hereunder.

B. TDA agrees to defend, indemnify and hold Specialist 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 Specialist's insurer provides insurance coverage for the act or omission complained of.

XII. INDEPENDENT CONTRACTOR:

A. Specialist 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 Specialist 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.

XIII. LICENSE: STANDARD OF DENTAL CARE:

A. Specialist represents and warrants that Specialist and all other dentists, specialists, 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 the Specialist has the staff, personnel and facilities to provide dental services as described in this Agreement and the PLANS.

XIV. WAIVER

A. 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.

XV. GOVERNING LAW

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

IF SIGNING AS AN INDIVIDUAL:
BY_____
(Dentist's Signature)
_____
Dentist Name (Please Print)
Date:_____
SSN# or TIN#_____
Address:_____
_____
_____

IF SIGNING ON BEHALF OF GROUP/CORPORATION:
BY_____
(Authorized Signature)
_____
Name/Title of above (Please Print)
Date:_____
_____
Name of Professional Associate/ Corporate/Group (Please Print)
IRS Tax #_____
Address:_____
_____
_____

PLEASE SUPPLY THE FOLLOWING INFORMATION WHETHER INDIVIDUAL OR GROUP:

Name of Professional Liability Insurance_____

Policy #_____Expiration Date_____Coverage Amount $_____

ACCEPTANCE
TOTAL DENTAL ADMINISTRATORS OF UTAH, INC.
BY_____
Plan Officer
Date_____

EXHIBIT A

TOTAL DENTAL ADMINISTRATORS OF UTAH, INC.

MEMBER DENTIST AGREEMENT – SPECIALIST

SUPPLEMENTAL PAYMENTS FROM CAPITATED FUNDED POOL

When the Specialist 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 Specialist shall receive the following supplemental payments, for the eligible procedures performed by said Specialist, 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.

EXHIBIT A

TOTAL DENTAL ADMINISTRATORS OF UTAH, INC.

MEMBER DENTIST AGREEMENT – SPECIALIST

Any member whose Schedule of Benefits and Copayments includes Specialty Care services at the copayment charges should be charged, by the Specialist, the copayment as provided in the member's plan of coverage. The Specialist should submit to TDA for the supplemental payment (balance between the copayment and the contracted specialist fees in affect at the time dental care services are rendered). If a member's plan of coverage includes any of the following listed dental care procedures under the following specialist categories and is provided by such specialist, subject to general dentist referral and TDA authorization, a supplemental payment will be considered eligible:

ENDODONTICS

Code	Description
D0140	Limited oral exam (by specialist)
D0220	Periapical X-ray (by specialist)
D0230	Periapical X-ray (additional)
D3110	Pulp capping/direct
D3120	Pulp capping/indirect
D3220	Therapeutic pulpotomy
D3310	Root Canal – Anterior
D3320	Root Canal – Bicuspid
D3330	Root Canal – Molar
D3410	Apicoectomy/Periradicular surgery – anterior
D3430	Retrograde Filling each Root
D3450	Root Amputation
D3920	Hemisection
D3999	Endodontic access (open & drain only)

EXHIBIT A

TOTAL DENTAL ADMINISTRATORS OF UTAH, INC.

MEMBER DENTIST AGREEMENT – SPECIALIST

PERIODONTICS

Code	Description
D0150	Exam including Pre-Op Diag. Consult & Work Up
D0210	Intra-oral Complete Including Bitewing x-rays
D0230	Periapical X-ray (additional)
D4210	Gingivectomy or gingivoplasty/quad
D4211	Gingivectomy or gingivoplasty/tooth
D4220	Gingival curettage/quad
D4240	Gingival Flap procedure including Root Planing
D4260	Osseous Surgery/quad (including entry & closure)
D4320	Provisional Splinting-Intracoronal
D4321	Provisional Splinting-Extracoronal
D4341	Periodontal Scaling and Root Planing/quad
D4345	Periodontal Scaling w/gum inflammation
D4910	Periodontal maintenance following active therapy

ORAL SURGERY

Code	Description
D0150	Exam including Pre-Op Diag. Consult & Work Up
D0220	Periapical X-ray (by specialist)
D0230	Periapical X-ray (additional)
D7110	Routine extraction
D7120	Each additional routine extraction (same appointment)
D7130	Root removal – exposed roots
D7210	Surgical extraction
D7220	Soft tissue impaction
D7230	Partial bony impaction
D7240	Complete bony impaction
D7250	Surgical root recovery
D7270	Tooth reimplantation & stabilization
D7280	Surgical exposure of impacted tooth
D7286	Biopsy of oral tissue
D7310	Alveoloplasty/quad w/extraction
D7320	Alveoloplasty/quad w/o extraction
D7470	Removal of exostosismaxilla or mandible
D7510	Intra-oral I & D or abcess
D7911	Simple suture (includes post op. Visit)
D7960	Frenectomy
D7970	Excise hyperplastic tissue/quad