DELTA DENTAL®

Treating Provider Delta Dental PPO™ and Delta Dental Premier® Application Packet

Step 1.

- To start the application process, save the forms to your computer.

Step 2.

- Enter the requested information into the fields in the first PDF form in the packet. Don't print the forms and complete them by hand. (Note: As you fill out the PDF forms, many of your entries will automatically populate fields on other forms that require the same information, such as license number, name, address and TIN).

Step 3.

- Carefully review each completed PDF form. Fill in any blank fields. Forms with missing or inconsistent information will be returned to you.

Step 4.

- Print the signature pages and sign them by hand.

Step 5.

- Return your saved, completed forms by either email or fax.
- **Email:** Attach each form to your email. Return the forms to the person or department at the email address you received from us in the original email.
- **Fax:** Print the completed PDF forms and sign the signature pages by hand. Fax the forms to the person or department at the fax number you received from us in the original email.

#128700J (07/20)

DELTA DENTAL®

DDIC Participating Provider Agreement (Commercial Fee-for-Service) – Texas

1. Read, complete and return pages 1 through 11 of the following Agreement.

2. "In Witness Whereof," top of page 10:

- Select box **A** (solo practitioner) or box **C** (corporation or clinic).
- Enter the state license number and specialty (e.g. general dentist, pediatric dentist, oral surgeon, etc.).
- Enter the provider's individual NPI (Type 1).
- If you selected **C**, enter the title of the person signing.

3. "Business Information," page 10:

- Enter the telephone and fax numbers. Provide the email address for the business owner.

4. "Practice Location Information," page 10:

- Enter the telephone and fax numbers. Don't leave this section blank, even if this information is the same as the information that you entered above.

5. "Additional Practice Locations," page 11:

- Include any additional practice location(s) you want to contract under the same Taxpayer Identification Number. If there are no additional locations, enter "NA."
- Don't list any currently contracted practice locations.

6. "Fee Schedule" and "Initials," pages 10 & 11:

- Review the PPO fee schedule, which is included with this packet. (The numeric "Region Code" identifies the particular PPO fee schedule that applies to the practice location.)
- The contracting provider must **hand write** his/her initials in the fields titled "Initials" to confirm review and acceptance of the PPO fee schedule for services provided for PPO patients.

7 Print, sign and date page 10 (the "In Witness Whereof" section).

#129496C (07/20)

DELTA DENTAL®

DELTA DENTAL INSURANCE COMPANY
CONTRACTING PROVIDER AGREEMENT

(Commercial Fee-for-Service) - TEXAS

This Delta Dental Insurance Company Contracting Provider Agreement ("Agreement") is entered into by and between the undersigned dentist, dental partnership, professional dental corporation, dental clinic, or dental care provider ("Provider") and Delta Dental Insurance Company (hereinafter "Delta Dental").

This Agreement shall become effective upon Delta Dental's initial written notice to Provider as set forth in Section 1.2, below.

RECITALS

A. Delta Dental issues various preferred provider contracts to purchasers of dental care benefit programs called Dental Provider Organization ("DPO") and Delta Dental Premier® ("Premier"), collectively referred to herein as "Programs," for designated eligible enrollees ("Enrollees"). Such Programs arrange for dental care providers contracted with Delta Dental ("Contracting Providers") to provide dental services ("Program Services") to Enrollees on a fee-for-service basis. Program Services include dental care services for which the Program is obligated to pay pursuant to an Enrollee's Plan, or for which the Program would be obligated to pay pursuant to an Enrollee's Plan but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, or alternative benefit payments.

B. Delta Dental Program contracts are also issued to Program purchasers by entities in other states that are either directly affiliated with Delta Dental or are other member companies of the Delta Dental Plans Association ("DDPA"). The terms and conditions of this Agreement shall also be applicable to Programs issued or administered by such other entities and Program Services provided to their Enrollees.

I. SELECTION AND CONTRACTING

1.0 Eligibility. Provider must submit all required credentialing documents and information for each and every licensed dentist (including Provider) whom Provider intends to render dental services to Enrollees on Provider's behalf ("Treating Professionals") and receive approval from Delta Dental for each such Treating Professional who meets Program credentialing and periodic re-credentialing criteria as determined by Delta Dental. Such criteria include, but are not limited to:

(a) Licensure. Each Treating Professional shall hold and continue to hold a currently valid, unrestricted license to practice dentistry issued by an appropriate state agency. No Treating Professional's license shall have been suspended, revoked or terminated or subject to terms of probation or other restriction within the past five (5) years. No Treating Professional shall have been excluded from participating in any government- sponsored programs.

(b) Facilities and Equipment. With respect to each and every facility where Enrollees shall receive treatment, Provider shall ensure that such facilities are of adequate capacity and are clean, safe and readily accessible to Enrollees. All equipment used in such facilities that is required to be licensed or registered shall be licensed or registered and regularly checked as required by state and federal law to ensure that it meets health and safety standards, is environmentally safe and technically accurate. Personnel required by law to be licensed or certified to operate such equipment shall be so licensed or certified.

(c) Insurance. Provider shall secure and maintain from insurance companies acceptable to Delta Dental and approved to conduct business in the state where Provider is located, professional liability insurance, commercial general liability insurance and such other insurance as required by reasonably sound business judgment to protect Provider and each Treating Professional ("Insureds") and the Insureds' partners, shareholders, directors, officers, members, employees and agents against losses and liabilities attributable to their acts or omissions in the performance of this Agreement. Such insurance shall have limits of coverage considered reasonably adequate

by Delta Dental for the risk insured against. Provider shall give Delta Dental written notice of any policy changes, cancellation or other termination.

1.1 Selection. Delta Dental may, at its sole discretion, select Provider to contract with, based upon Delta Dental's determination of Provider's eligibility. Selection may also be contingent on Delta Dental's need for the Provider's services, as permitted by applicable law. Delta Dental may also, at its sole discretion, select or deselect individual Treating Professionals based upon Delta Dental's quality and utilization review program, as described in Section V of this Agreement.

1.2 Notification of Selection. Delta Dental shall notify Provider in writing of Provider's selection as a Contracting Provider and when any Treating Professional has been approved to treat Enrollees.

II. REQUIRED ADMINISTRATIVE PRACTICES, DISCLOSURES AND LEGAL COMPLIANCE

2.0 Dental Services. Provider agrees to provide Program Services for any Delta Dental Program to Enrollees in accordance with the terms, benefits, limitations and/or exclusions for the Enrollee's Plan.

2.1 Availability. Dental services are to be available during Provider's regular business hours. Emergency Services shall be available to patients of record twenty-four (24) hours per day, seven (7) days per week, including vacations and holidays, by means including, but not limited to, a telephone number or referral service that patients who may require emergency services can use after normal business hours. Provider shall make known to current and prospective Enrollees the hours of operation and the provisions for after-hour emergency services in all facility locations in which the Provider or Treating Professionals under Provider's supervision are providing services. Provider may not impose any limitations on the acceptance or treatment of Enrollees not imposed on other patients.

2.2 Locations. Provider shall submit information as required by Delta Dental to accurately maintain its records for each office where Enrollees will receive dental services from Provider. This includes, but is not limited to the name and Tax Identification Number, as registered with the U.S. Internal Revenue Service, to be used by Delta Dental to issue payment for services, any business entity name, new or deleted office locations, the attributes associated with each office (e.g., hours open, languages spoken), etc. Office locations will not be activated until at least one dentist at the location, in the appropriate specialty, is approved by Delta Dental as a Treating Professional per Section 1.0.

2.3 Eligibility Verification. Provider shall verify an Enrollee's eligibility to receive Program Services at or before each visit in accordance with procedures established by Delta Dental. Failure to verify eligibility may result in forfeiture of payment, including applicable Enrollee payments.

2.4 Enrollee Grievance Procedures. Provider agrees to cooperate with Delta Dental in identifying, investigating and resolving Enrollee grievances pursuant to applicable review procedures as described in Delta Dental's Dentist Handbook or in written correspondence connected with specific grievances, and in accordance with state and federal regulatory guidelines as applicable. Provider agrees to comply with all final complaint and grievance determinations by Delta Dental.

2.5 Standard of Care. This Agreement shall not affect the provider/patient relationship between Provider and Enrollees. Provider shall render all services in accordance with generally accepted dental practice and standards prevailing in the professional community at the time of treatment. It is Provider's responsibility to disclose various treatment options and the estimated costs associated with each option, regardless of whether or not they are Program Services under the Enrollee's Plan, and to secure the written consent of the Enrollee per Sections 4.5 and 4.6.

2.6 Treating Professionals. Each Treating Professional is required to sign a separate Contracting Provider Agreement. Provider shall not permit any Treating Professional to provide services to Enrollees on Provider's behalf unless such Treating Professional has been approved by Delta Dental as a Contracting Provider. Provider shall ensure that each Treating Professional complies with the terms and conditions of this Agreement.

2.7 Required Disclosures. Provider agrees to notify Delta Dental immediately in writing upon the occurrence or discovery of any of the following:

(a) The license to practice dentistry of Provider or any Treating Professional expires and/or is not

renewed, is suspended, revoked, terminated or subject to terms of probation or other restriction;

(b) Provider or any Treating Professional becomes the subject of any disciplinary proceeding or action before a state or federal agency;

(c) Provider or any Treating Professional ceases to participate, is suspended or loses eligibility to participate in any state or federally sponsored dental program;

(d) Provider or any Treating Professional is accused or convicted of fraud or a felony;

(e) The cancellation, termination or expiration of insurance coverage required under this Agreement;

(f) A malpractice action is instituted, settled or decided against Provider or any Treating Professional;

(g) Provider files a voluntary petition or an involuntary petition is filed against Provider seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other laws governing insolvency or debtor relief;

(h) An act of nature or any event beyond Provider's reasonable control occurs which substantially interrupts or interferes with all or a portion of Provider's practice or which has a material adverse effect on Provider's ability to perform hereunder;

(i) A material change in the membership, ownership, and/or officers of Provider's dental practice/corporation; or

(j) Any other situation arises which could reasonably be expected to affect Provider's ability to carry out the obligations of this Agreement.

To the extent reasonably appropriate and subject to any applicable state or federal fair hearing requirements, Provider shall immediately restrict, suspend or terminate a Treating Professional from providing services to Enrollees upon the occurrence of any of the events referenced in Section 2.7. If Provider fails to act as required by this paragraph with respect to a Treating Professional, Delta Dental shall have the right to immediately prohibit the Treating Professional from continuing to provide services to Enrollees.

2.8 Legal Compliance. Provider and Treating Professionals shall:

(a) Treat Enrollees with the same quality and provide access to care consistent with the balance of Provider's practice and not differentiate or discriminate against any Enrollee on the basis of source of payment; and

(b) Not unlawfully differentiate or discriminate against an Enrollee, employee or applicant for employment on the basis of race, religion, color, national origin, ancestry, place of residence, physical handicap, medical condition, marital status, sexual orientation, age or sex; and

(c) Comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Public Law 103-227 (US. Pro-Children Act of 1994 [20 USC 6081, et. seq.]) and Section 1352 of Title 31, United States Code regarding prohibitions against using federal funds for lobbying; and

(d) Not employ or contract with, directly or indirectly, entities or individuals excluded from participation in Medicare or Medicaid under sections 1128 or 1128A of the Social Security Act, for the provision of dental services, utilization review, medical social work or administrative services; and

(e) Not condition treatment or otherwise discriminate on the basis of whether an Enrollee has executed an advance directive (as advance directive is defined under federal law); and

(f) Comply with all applicable federal, state and local laws and regulations relating to administrative simplification, security, and privacy of individually identifiable Enrollee information, including but not limited to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2.9 Confidentiality of Delta Dental Information. Provider and Treating Professionals shall keep confidential

and take necessary precautions to prevent the unauthorized disclosure of Delta Dental's confidential and proprietary information, including without limitation its financial arrangements with Contracting Providers and any other information compiled or created by Delta Dental and identified in writing as confidential and proprietary. Upon the termination or expiration of this Agreement, Provider shall return to Delta Dental all confidential and proprietary information in the possession of Provider or any Treating Professional.

2.10 Provider Directory. Provider authorizes Delta Dental, its affiliates, and other member companies of the DDPA to include the name of the Provider and Treating Professional(s) and Provider's office address(es) in lists and directories it provides in various media for the use of current or prospective Enrollees to whose Programs this Agreement applies.

III. PROGRAM ADMINISTRATION

3.0 Administration. For the purposes of this Section III of the Agreement, the term "Delta Dental" applies to the named party to this Agreement, its affiliates, and other DDPA member companies. Delta Dental shall perform or contract for those services necessary to the administration of the Programs.

3.1 Eligibility/Authorizations. Delta Dental shall confirm the Program eligibility of Enrollees and the benefits under the Enrollee's Plan through the Delta Dental web site and automated telephone services.

3.2 Processing Policies and Procedures. Delta Dental shall make information describing Delta Dental's general policies and procedures and Program policies and procedures available to Provider and Treating Professionals, including (where different) those of other DDPA member companies, through its Dentist Handbook or web site and upon request.

3.3 Benefit Determinations. Delta Dental shall be solely responsible for interpreting the terms of and making final benefit determinations under each Program with respect to Program Services and/or Enrollee payments.

3.4 Rationale for Rejection of Claim. Delta Dental shall, where required, disclose the rationale used in rejecting or denying a claim submitted by Provider. Delta Dental shall pay Provider's claims under the Programs in accordance with applicable state or federal prompt payment laws.

IV. COMPENSATION

4.0 Fees. Based on the Enrollee's Plan, Delta Dental and Provider mutually agree to the Contracted Fees set forth in the Fee Schedule(s), attached hereto. These Schedule(s) (including amended versions thereof) are incorporated into this Agreement by this reference at the time they are issued to Provider (see also Section 8.0 of this Agreement). The Contracted Fees set forth in the Schedule(s) shall be considered the "Accepted Fee" (the Accepted Fee is sometimes referred to as the "Maximum Plan Allowance"). Provider understands that Delta Dental offers other dental plans outside of the Programs identified in this Agreement. The Contracted Fees set forth in the schedule(s) or established by any Premier Addendum shall be considered the "Accepted Fee" for services provided to Enrollees who are covered under any Delta Dental plan, unless the Provider has a separate contractual agreement with Delta Dental for network participation in any other specific Program(s).

(a) Provider agrees to accept no more than the lesser of the Accepted Fee or the Submitted Fee as payment in full for a single procedure, when the particular procedure is a Program Service of an Enrollee's Plan.

(b) For each single procedure provided and submitted on a claim, Delta Dental, an affiliate, or DDPA member company will determine the Maximum Contract Allowance based on the Enrollee's Plan as shown on the Provider's payment statement.

(c) Delta Dental shall calculate the amount the Enrollee will pay ("Patient Pay" amount) by applying the provisions (e.g. contract benefit level) of the particular Enrollee's Plan against the Maximum Contract Allowance. The patient is responsible for the remaining amount not paid by Delta Dental, up to the amount of the Accepted Fee.

(d) Provider shall not disclose Contracted Fees to a third party without the express permission of Delta Dental.

4.1 Claim Submission Requirements. Provider agrees to submit claims and provide Delta Dental with claim data according to the policies and procedures set forth in the Dentist Handbook or on the Delta Dental website and consistent with requests in any written communications between Delta Dental and the Provider. Provider further agrees to follow any applicable state and federal laws with respect to claim submission requirements or data elements associated with such transactions. This includes, but is not limited to, the guidelines found in the Health Insurance Portability and Accountability Act (HIPAA). Provider also agrees, upon request, to provide any other information that will enable Delta Dental to meet federal, state and local reporting requirements. Provider further agrees to:

(a) Submit complete and accurate claims for all services provided to Enrollees, whether Program Services or not;

(b) Include the fee regularly charged by Provider for such services;

(c) Use claim forms or formats acceptable to Delta Dental;

(d) Submit radiographs, charting, surgical reports, etc., to Delta Dental when required by the policies and procedures referenced in Section 3.2 of this Agreement;

(e) Submit claims within twelve (12) months after the date services were performed. Should any amount be denied by Delta Dental for late submission, Provider agrees not to charge the Enrollee any balance that would have been paid by Delta Dental if the claim had been submitted on a timely basis.

4.2 Enrollee Payments. Provider shall bill and collect any deductible, copayment and/or coinsurance from the Enrollee in the amounts determined by Delta Dental, its affiliates, or another DDPA member company, to be applicable based on the Enrollee's Plan. Provider shall not waive, reduce or rebate any such amount determined to be an Enrollee's payment obligation.

4.3 Prohibition against Certain Billings and Collections. Provider agrees to accept payments described in Paragraph 4.0, from Delta Dental, its affiliates or a DDPA member company, plus the Enrollee payments, pursuant to Paragraph 4.2, as payment in full for Program Services and not to seek any surcharge or other additional payment from an Enrollee, regardless of whether or not payment is received from Delta Dental, its affiliates or a DDPA member company. Whenever Delta Dental receives notice of a surcharge, it shall take appropriate action. Neither Enrollees nor a Program's sponsoring entity shall be liable to Provider or any Treating Professional for any sums owed to Provider by Delta Dental. The foregoing shall not preclude Provider from billing and collecting authorized Enrollee payments pursuant to Paragraph 4.2, or third party collections in accordance with Paragraph 4.4.

4.4 Third Party Payments. Provider shall cooperate with Delta Dental in the proper collection of third party payments including coordination with other coverage, workers' compensation, third party liens and other third party liability. Provider agrees to disclose any other insurance for which the Enrollee is also eligible on any claims submitted to Delta Dental. Furthermore, if Delta Dental is secondary, the Provider agrees to provide the explanation of benefits provided by the carrier that adjudicated the claim as the primary payer.

4.5 Optional Treatment. If Provider proposes to render optional treatment (e.g. a treatment for which the Enrollee's Program covers a less expensive professionally accepted treatment), Provider shall obtain an optional treatment form, executed by the Enrollee or the Enrollee's legal representative, prior to treatment. Such form shall disclose the Provider's Contracted Fee for the optional treatment, the Contracted Fee for the less expensive treatment, and the fact that the Enrollee is responsible for the difference between those fees plus the copayment. Total reimbursement for any optional treatment shall not exceed the Accepted Fee (as defined in Section 4.0 of this Agreement) for the rendered procedure(s).

4.6 Non-Program Services. Provider shall not charge an Enrollee for non-Program Services unless Provider obtains a financial responsibility form, executed by the Enrollee or the Enrollee's legal representative, prior to treatment. Such form shall disclose the Provider's actual charges for the non- Program Services and the enrollee's financial obligation therefor.

4.7 Deductions and Refunds. Delta Dental shall have the right to deduct and set off from subsequent amounts due to Provider any amounts owed by Provider to Delta Dental or other member companies

of DDPA, or to Enrollees as a result of Provider's failure to fulfill any business or patient obligation under this Agreement or Delta Dental's policies and procedures. Enrollees shall not be liable to Provider or any Treating Professional for any such amount deducted or set off by Delta Dental (or refunded by Provider) and Provider agrees not to attempt to collect any set off amount from Enrollees or maintain any action at law against Enrollees to collect such amounts.

4.8 Non-Reimbursable Service Claims Submission. The submission of a claim for items or services which have not been provided as claimed is not reimbursable under any Program and is subject to applicable provisions of state and federal criminal laws.

V. QUALITY AND UTILIZATION REVIEW

5.0 Delta Dental's Responsibilities. Delta Dental may be required by law to conduct quality and utilization review activities that identify, evaluate and remedy problems relating to access, continuity and quality of care, utilization and the cost of services. Delta Dental shall maintain standards, policies and procedures for credentialing and recredentialing, and quality and utilization review of Contracting Providers, Treating Professionals, other health care professionals, and facilities providing dental services to Enrollees.

As part of its review activities, Delta Dental may also use or disclose Provider's Tax Identification Number (TIN), National Provider Identifier (NPI) or other attributes to conduct analysis of accessibility, continuity and quality of care or to perform other dental benefit administration activities.

5.1 Provider's Responsibilities. Provider and Treating Professionals shall cooperate and comply with Delta Dental, and designated representatives of organizations engaged by Delta Dental, in connection with its quality and utilization review activities, including but not limited to credentialing and recredentialing, patient record reviews, and facility audits. Provider shall provide Delta Dental timely clarification of issues raised in connection with a review of treatment and/or financial records.

5.2 Language Assistance Capabilities. Provider shall contact Delta Dental if an Enrollee requests or evidently requires interpretation services in any language, which services will immediately be arranged by Delta Dental at no cost to the Enrollee or the Provider. Provider shall notify Delta Dental of any language assistance capability of the Provider or the office staff, and any changes in such capability.

VI. RECORDS AND AVAILABILITY FOR INSPECTION

6.0 Dental Records. Provider shall ensure that an accurate and complete patient (treatment and financial) record for each Enrollee is established and maintained in Provider's facility. At a minimum, such records shall include personal and health information about the Enrollee, a description of all services rendered to the Enrollee, and charges made and payments received therefore, as dictated by generally accepted dental practice and standards.

6.1 Access to Dental Records. Subject to compliance with applicable federal and state laws and professional standards regarding the confidentiality of patient records, Provider shall assist Delta Dental in achieving continuity of care for Enrollees through the sharing of patient records for services rendered to Enrollees. Provider's obligations under this Paragraph shall include, without limitation:

(a) Providing Delta Dental with copies of Enrollee patient records that are in the custody of Provider or any Treating Professional;

(b) Allowing Delta Dental authorized personnel, its designated representatives, accreditation and review organizations and government agencies access to such records on Provider's premises during regular business hours;

(c) Upon reasonable request, providing copies of an Enrollee's patient records to any other Contracting Provider treating such Enrollee.

6.2 Inspection, Audit and Maintenance. Provider and each Treating Professional shall maintain the confidentiality of all Enrollee identifiable information, patient records and treatment in accordance with state and federal law.

Provider and each Treating Professional shall maintain such records and provide such information to Delta Dental, the United States Department of Health and Human Services, or any other appropriate governmental official having jurisdiction as may be necessary for compliance by Delta Dental with state

and federal law and the rules and regulations duly promulgated thereunder, for a period of at least ten (10) years, or longer as required by state or federal law. All facilities, offices, records, books and papers of Provider and each Treating Professional pertaining to Enrollees shall be open to inspection and copying by Delta Dental, its designated representatives, accreditation and review organizations, and state and federal authorities having jurisdiction over the Program during normal business hours. Provider and each Treating Professional shall comply with any requirements or directives issued by Delta Dental, accreditation and review organizations and government agencies as a result of such evaluation, inspection or audit of Provider or a Treating Professional. The provisions of this paragraph shall survive termination of this Agreement for the period of time required by state and federal law.

VII. TERM AND TERMINATION

7.0 Term. When executed by both parties, this Agreement shall commence upon the Provider's selection date as notified by Delta Dental, pursuant to Paragraph 1.2 of this Agreement, and shall continue for one year. Thereafter, the agreement shall automatically renew and be in effect until terminated in accordance with the terms of this Agreement.

(a) If this Agreement is signed by a Treating Professional that provides dental services on behalf of and under the TIN of another Provider, then the term of this Agreement shall coincide with the agreement executed by that Provider, unless this Agreement is terminated earlier.

7.1 Termination.

(a) Provider may terminate this agreement after the initial one year term by giving Delta Dental ninety (90) days written notice of termination, subject to the provisions of Section 8.0 of this Agreement.

(b) Delta Dental may terminate this Agreement on thirty (30) days written notice, unless a longer notice is required by law. Delta Dental may immediately terminate this Agreement upon the occurrence of any of the events set forth in Section 2.7 (a) through (e) (Required Disclosures) subject to any applicable limitations of state or federal law. Delta Dental will provide a terminated Contracting Provider an opportunity to appeal such termination as required by applicable state or federal law or by Delta Dental policies and procedures. Any such appeal process for a termination shall replace the dispute resolution procedures described in Section VIII of this Agreement.

If this Agreement is terminated by Delta Dental, Provider may not seek to become a Contracting Provider until Provider demonstrates to Delta Dental's satisfaction that the issues which resulted in the termination of the Agreement have been resolved. Furthermore, unless otherwise stated by Delta Dental at the time of termination of the Agreement, Provider may not reapply for a period of at least twelve (12) months following the termination of this Agreement.

7.2 Continuing Obligations upon Termination. In the event of notice of termination of this Agreement or a Program, Provider shall continue to schedule and honor existing appointments of Enrollees until the effective date of termination. As of the effective date of termination of this Agreement or a Program, the provisions of this Agreement shall be considered of no further force or effect whatsoever and each of the parties shall be relieved and discharged here-from, except that:

(a) Termination shall not affect any rights or obligations that have previously accrued or shall thereafter arise with respect to any occurrence prior to the effective date of termination and any such rights and obligations shall continue to be governed by the terms of this Agreement;

(b) Unless Delta Dental makes other reasonable and dentally appropriate provision for the performance of services, Provider shall complete all dental services begun (but not completed) prior to the effective date of the termination.

(c) For a period of one year following termination of this Agreement for any reason, Provider agrees to notify all Enrollees that the Provider is no longer contracted to render services as a Contracting Provider.

VIII. MISCELLANEOUS PROVISIONS

8.0 Amendments. Provider agrees to be bound by amendments to this Agreement with advance written

notice from Delta Dental, as required by state or federal law. If Provider does not wish to be bound by such amendment, Provider shall notify Delta Dental of his/her intent to terminate this Agreement within the notice period. Provider shall comply with any amendment required by law until the effective date of termination. The foregoing notice requirements shall not apply to amendments agreed to by mutual written consent of the parties or to amendments required for compliance with applicable law and regulations.

8.1 Governing Law. This Agreement shall be governed, construed and enforced in accordance with the laws of the state where the Provider is located and the United States of America, as amended, and the regulations adopted thereunder, including but not limited to those enforced by a state insurance regulatory agency. Any provisions required to be included in this Agreement by state or federal law or by regulatory agencies with jurisdiction over Delta Dental shall bind Delta Dental, Provider and each Treating Professional whether or not expressly provided in this Agreement. Provider acknowledges that this Agreement may be subject to approval by such regulatory agencies and may be amended by Delta Dental, as set forth in Paragraph 8.0, in order to comply with applicable law and regulations.

8.2 Incorporation by Reference. All exhibits, addenda and attachments to this Agreement, including Delta Dental's Dentist Handbook, policies and procedures referenced in Section 3.2, are an integral part of this Agreement and are incorporated in full herein by this reference as if they are set forth at length.

8.3 Entire Agreement. This Agreement, contracted fee addendums, schedules, appendices, and amendments hereto, contains all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement and supersedes all prior agreements, either oral or in writing, with respect to the subject matter hereof. Notwithstanding the foregoing, this Agreement is not intended to supersede separate agreements that may be entered into with Delta Dental to contract with other provider networks.

8.4 Independent Contractor Relationship. The relationship between Delta Dental and Provider is that of independent contractors. Provider, Treating Professionals, and their respective employees and agents are not nor shall they be construed to be employees or agents of Delta Dental. Delta Dental, its employees and agents are not nor shall they be construed to be members, partners, employees or agents of Provider.

8.5 Indemnification. Delta Dental and Provider shall each agree to defend, indemnify and hold harmless the other party and its directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability arising out of or related to the performance or nonperformance by the indemnifying party or their respective employees or agents under this Agreement.

8.6 Assignment. This Agreement, being intended to secure the personal services of Provider, shall not be subcontracted, assigned, transferred or pledged in any way by Provider and shall not be subject to execution, attachment or similar process, except that Delta Dental may assign this Agreement and its rights, interests and benefits hereunder to any Delta Dental parent company, affiliate or related entity.

8.7 Disputes.

(a) Except as otherwise provided in this Agreement, disputes between Delta Dental and Provider arising out of this Agreement shall be first resolved through the provider dispute resolution procedure described in the Dentist Handbook.

(b) This subsection shall only apply to disputes arising from: (i) the processing by Delta Dental of a dental claim paid or denied in whole or in part; or (ii) a request by Delta Dental for reimbursement because of an overpayment of a dental claim; or (iii) a request for a refund because services are deemed by Delta Dental to be of unsatisfactory quality or inappropriate care.

If such disputes are not resolved by the provider dispute resolution procedure described in subsection (a), such disputes shall be subject to binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"), and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. The initiating party shall give written notice to each other party of its demand to arbitrate on a form provided by the AAA, which notice shall contain a statement setting forth the nature of the dispute, the amount involved, if any, and the remedy sought, and shall file at any regional office of the AAA

three copies of the notice, together with the appropriate filing fee required by the AAA. Arbitration hearings shall be held in a regional AAA office unless otherwise agreed upon between Delta Dental and Provider. Such obligations are not terminated upon termination of this Agreement by rescission or otherwise. Any demand for arbitration shall be submitted within one year from the date of the action that is the subject of the arbitration.

Disputes of any other nature not described in this subsection (b) shall only be subject to binding arbitration by mutual agreement of Delta Dental and Provider.

Provider acknowledges by signing this Agreement that Provider affirmatively agrees to this provision.

8.8 Notices and Communications.

(a) Notices. Any notice of material changes required under this Contracting Provider Agreement shall be sent to a party's email address or mailing address of record by United States first-class mail or by overnight delivery. Any such notice sent by first-class mail shall be deemed to have been received by the addressee seventy-two (72) hours after the notice has been deposited in the U.S. mail. If sent by overnight delivery or email, notice shall be deemed to have been received by the addressee the next business day.

(b) Communications. Provider agrees to receive email communications from Delta Dental.

Either party may change the place to which notice and communications are sent by providing an update to the other party of any change of address or change of email address.

[Intentionally Left Blank]

8.9 Signatures: The signatories hereto represent and warrant that they have read the Agreement, understand it and are authorized to execute it on behalf of their respective principals or co-owners.

IN WITNESS WHEREOF, as of the date(s) written below, Delta Dental Insurance Company has executed this Agreement through its authorized representative, AND the undersigned Provider has executed this Agreement as (SELECT ONE):

- ○ (A) an individual dentist owner of his/her practice (unincorporated)
- ○ (B) an individual Treating Professional associated with Provider/business indicated below
- ○ (C) a dentist or other authorized person who is an officer of the partnership/corporation/clinic
  Title of person signing below _____

If the person signing below is a dentist, complete the following:

State License #: _____ Individual NPI (type 1): _____

Specialty: ○ General Dentist ○ Orthodontist ○ Oral Surgeon ○ Prosthodontist
○ Pedodontist ○ Endodontist ○ Periodontist ○ Anesthesiologist

PROVIDER

Signature Date

Print Name Title of Person Signing

Email address for Notices under Section 8.8

DELTA DENTAL INSURANCE COMPANY
1130 Sanctuary Parkway
Alpharetta, GA 30009

Daniel W. Croley, DMD
Vice President and Chief Dental Officer

Business Information:

IRS Tax Identification Number (TIN) Business NPI (Type 2)

Legal Name of Dentist/Business Entity

Business/Mailing Address City State ZIP

Contact Telephone # Fax # Email Address

Practice Location Information (If this Agreement applies to more than one practice location, please use the next page)

Doing Business As (DBA) Name

Practice Location Address City State ZIP (+4 codes)

Contact Telephone # Fax # Email Address

Fee Schedule: RC-69 Initials: _____

Please email this entire signed agreement to our Provider Onboarding department at ProfessionalServices@delta.org. Once the process is completed, we will send notice of your participation.

Additional Practice Locations*

Doing Business As (DBA) name

Practice Location Address | City | State | ZIP (+4 codes)

Telephone # | Fax # | Email Address

Fee Schedule: ____________________ Initials: ____________

Doing Business As (DBA) name

Practice Location Address | City | State | ZIP (+4 codes)

Telephone # | Fax # | Email Address

Fee Schedule: ____________________ Initials: ____________

Doing Business As (DBA) name

Practice Location Address | City | State | ZIP (+4 codes)

Telephone # | Fax # | Email Address

Fee Schedule: ____________________ Initials: ____________

Doing Business As (DBA) name

Practice Location Address | City | State | ZIP (+4 codes)

Telephone # | Fax # | Email Address

Fee Schedule: ____________________ Initials: ____________

* To help maintain directory accuracy required by state and federal law, a provider can be listed at up to five practice locations.

INSTRUCTIONS FOR COMPLETION OF THE CONFIDENTIAL CREDENTIALING APPLICATION

The Confidential Credentialing Application must be completed by the contracted dentist. Your responses on this application will be used to determine whether you meet the eligibility criteria for participation in the network. As a treating dentist, you must maintain eligibility throughout the term of your participation. Responses must be legible. You may include any response which cannot be completed in the spaces provided on supplementary sheets of paper and attach them to your submittal. **Do not leave any fields blank**. If an item is not applicable, indicate N/A.

You must include the following with this completed application:
(Use this checklist as a guide)

- Application completed in its entirety for an initial credentialing or recredentialing submittal
- Copy of **all** current State license(s)
- Copy of **all** current DEA registrations (if applicable)
- Copy of current State Controlled Dangerous Substance (CDS) certificate (if applicable)
- Copy of the certificate of current Professional Liability Insurance policy face sheet, showing expiration dates, dollar amount of liability limits and dentist's name
- Proof of American Board Certification (if applicable)
- Copy of Curriculum Vitae/Resume (include last five (5) years of dental work history, or date of graduation from dental school)
- Copy of current state-issued driver's license or identification card
- Copy of diploma or specialty training certificate

CONFIDENTIAL CREDENTIALING APPLICATION

Dentist Information

Last name: _____ First name: _____

Type 1 NPI: _____ Date of birth: _____

Dentist email address: _____

Primary Specialty Type:

☐ General dentist ☐ Orthodontist ☐ Oral surgeon ☐ Prosthodontist
☐ Pediatric dentist ☐ Endodontist ☐ Periodontist

Primary Location

Practice name : _____ Start date (MM/YYYY): _____

Practice address: _____

City: _____ State: _____ ZIP: _____

Confidential credentialing contact name: _____

Credentialing contact email: _____

Direct number: _____ Fax number: _____

Dentist information continued

Last name: _____ First name: _____ Middle initial: _____

Other name(s) used: _____

Dentist Social Security number: _____ (Mandatory field needed for primary source verifications)

☐ DDS ☐ DMD ☐ Other Gender: ☐ Male ☐ Female ☐ Other ☐ Undisclosed

Dental school: _____ MM/YYYY graduated: _____

Specialty school (if applicable): _____ MM/YYYY graduated: _____

Are you "American Board Certified" in any of the below Specialties: if yes, please check the applicable board

☐ ABO-Orthodontist ☐ ABOMS-Oral Surgeon ☐ ABP-Prosthodontist
☐ ABPD-Pediatric Dentist ☐ ABE-Endodontist ☐ ABP-Periodontist

If you have hospital privileges check here ☐ If no, skip to the next question. If yes, list the hospital(s) for which you have privileges. _____

Licenses and Permits

Dental License#: _____ State: _____ Exp. date: _____

Additional Dental License(s) #:_____ State: _____ Exp. date: _____

DEA Certificate #: _____ Exp. date: _____

If you no longer have a DEA, please complete the below information. If not applicable, please skip to the next question.

Reason for not renewing DEA: _____

If a patient needs narcotics prescribed, they will be: ☐ Referred to another dentist/oral surgeon ☐ Referred to their primary care physician. If another dentist is prescribing, please confirm the prescribing dentist's name below:

Dentist's name: _____ DEA #, if known: _____

Controlled Substance Certificate #: _____ Exp. Date: _____

Do you have a current license or permit to administer conscious sedation/general anesthesia?
☐ Yes ☐ No ☐ N/A

Type: ☐ IV Sedation ☐ General Anesthesia Permit #: _____ Exp. Date: _____

Professional Liability

Effective date: _____ Liability type: ☐ Professional ☐ Tort ☐ Self-insured

Prof. Liability Ins. Co: _____ Policy #: _____

Liability limits: (Each claim): _____ (Aggregate claim): _____
Exp. date: _____

Past 5 Years Dental Work History	Start Date: MM/YYYY	End Date: MM/YYYY
1.		
2.		
3.		
4.		

Explanation of gaps of six months or more within the past 5 years:	Start Date: MM/YYYY	End Date: MM/YYYY

If you are a recent dental school graduate, please enter your state board dental license effective date here: _____

Professional Attestation and Questions		
I. Credentialing History (Please answer questions 1 - 10 below. For any "Yes" answer, explain on a separate sheet of paper.)		
Yes	**No**	**In the Past 10 Years:**
☐	☐	1. Has your license to practice in any jurisdiction, whether past or still pending, been denied, restricted, limited, suspended, revoked, not renewed, placed under probation, subjected to disciplinary or non-disciplinary action, or otherwise sanctioned, limited or curtailed?
☐	☐	2. Has your professional liability insurance ever been denied, suspended, revoked, canceled, or not renewed?
☐	☐	3. Has your Federal and/or State DEA license or applicable drug license ever been denied, suspended, canceled or not renewed, or subjected to any disciplinary action?
☐	☐	4. Has your status as a dentist ever been denied, suspended, canceled or sanctioned by any municipal, state, federal, or any other governmental agency (e.g. Medicare, Medicaid or Denti-Cal) HMO, EPO, PPO or other prepaid health plan including being listed on OIG, SAMs, or a State Exclusion List?
☐	☐	5. Are your privileges or memberships at any hospital, institution (military service) and/or HMO currently under investigation or have they ever been denied, suspended, reduced or not renewed?
☐	☐	6. Have you ever been denied membership, or renewal of membership, or been subject to disciplinary proceedings for a medical, dental or ethical reason by any dental/professional organization?
☐	☐	7. Are you unable to perform any procedures within the scope of privileges and duties in your position as a health care dentist, with or without reasonable accommodations required by the Americans With Disabilities Act, within accepted standards of professional performance and without posing a direct threat to patients?
☐	☐	8. Do you currently, or did you in the last five years, engage in the unlawful use of illegal drugs, including the improper use of prescription drugs?
☐	☐	9. Do you have any felony or misdemeanor charges pending against you or have you ever been convicted of a felony, or pleaded "nolo contendere" to a felony?
☐	☐	10. Have you been involved in ANY malpractice (or any other civil) claims/lawsuits, settlements or judgments within the last 10 years? If yes, please provide detailed information on a separate sheet of paper including docket number of the case, location of the court, names of the parties, plaintiff(s) and defendant(s), dates of the incident(s), description of the incident(s), your involvement, current disposition, and the amount of the settlement(s).

II. Compliance & Malpractice Insurance (Answer questions 11 & 12. For any "NO" answer, explain on a separate sheet of paper.)		
Yes	No	
☐	☐	11. Do you follow Center for Disease Control guidelines for Infection Control in Dental Health-Care Settings and observe all applicable laws and regulations related to the practice of dentistry including, but not limited to, those dealing with infection control and employee safety in the workplace?
☐	☐	12. Do you have current professional malpractice insurance coverage and agree to maintain continuous, uninterrupted coverage while either a contracted dental dentist or an associate of a contracted dental dentist? Please note that under the terms of participation that you further agree to notify the Credentialing Department immediately of any policy cancellation, lapse in coverage, reduction in coverage maximum(s) or claims made.

I authorize the Credentialing Department 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, the undersigned, hereby certify that the information requested by the Plan and provided herein, is truthful, correct and complete in all respects. I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for denying participation or termination as a contracting dentist with the dental plan. The undersigned hereby agrees to notify the Plan immediately of any changes in the above information.

Upon request, dentists have the right to review the information in their credentialing file and to ask for correction of any error or omission believed to be significant. To be accepted, any such requests must be submitted in writing to the Provider Onboarding department within 365 days of the dentist's last submission of completed credentialing forms. Dentists have the right to submit a written appeal to refute the basis for any adverse action by the Plan based on credentialing eligibility criteria. The time period in which to submit a written appeal is subject to state requirements and the dentist agreement. If the adverse action decision is upheld upon appeal, dentists may request a hearing before a hearing panel.

I authorize receiving credential communications electronically.

Dentist Signature (no signature stamps):		Date:

DELTA DENTAL®

Practice Location Information For Online Dentist Directory Form

1. **Please fill out the following Practice Location Information For Online Dentist Directory.**

#131953 (12/20)

DELTA DENTAL

Practice Location Information For Online Dentist Directory

Instructions

1. If you are responding to a directory information request from us, please enter the Case Number indicated on the letter: _____.
2. If you are new to Delta Dental, please enter all the information requested on this form and submit all pages.
3. If you are currently a contracted network dentist:
   - Review and edit your directory profile and/or attest that your directory profile is correct:
     a. Register for Provider Tools: **https://www.deltadentalins.com/RSO/shared/registration_step1.jsp**
     b. Log in to your online account: **https://www.deltadentalins.com/dentists/**
   - Or, use this form to enter just the information that needs to be updated in your directory profile and/or to attest that your directory profile is correct. (Use "Find a Dentist" at **deltadentalins.com** to access and review your current directory profile.)
4. Practice location name (doing business as): _____
   Practice location address: _____
   City: _____ County: _____ State: _____ ZIP: _____
   Practice location telephone: _____ Practice location fax: _____
   Taxpayer Identification Number (TIN): _____ Organization NPI (Type 2): _____
   Practice Location Organization Subpart NPI (If applicable): _____
5. Dentist name: _____
   First name Initial Last name
   Specialty: _____ License number: _____ State(s): _____
6. Dentist's NPI (Type 1): _____ ☐ Male ☐ Female ☐ Other ☐ Undisclosed
7. Dental school #1: _____ Graduation year: _____
   Dental school #2: _____ Graduation year: _____
8. Type of practice:
   ☐ Solo ☐ Clinic ☐ Dental School ☐ Mobile clinic ☐ Essential Community Provider (ECP)
   ☐ Federally Qualified Health Clinic (FQHC) ☐ Group Practice ☐ Tribal Clinic ☐ Other _____
9. Office internet access (available to public): ☐ Yes ☐ No
   Practice location website address: _____
   Directory email (the official business email address): _____
   Practice location email: _____
   Note: The practice location email is not for public display. Its primary use is for Delta Dental to communicate with the practice location.
10. Special services provided at this location (please check all that apply):
    ☐ Accessible by public transit
    ☐ Treats adults with intellectual disabilities
    ☐ Treats children with intellectual disabilities
    ☐ Early morning appointments (before 9 am)
    ☐ Free parking
    ☐ Treats children
    ☐ Treats adults with physical disabilities
    ☐ Treats children with physical disabilities
    ☐ Treats special needs children
    ☐ Evening appointments (after 5 pm)
11. Accepting new patients: ☐ Yes ☐ No
12. Office hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

13. Wheelchair accessibility:

    Your office can be listed as accessible to persons who use wheelchairs if it meets certain "functional accessibility guidelines." Please indicate whether your office meets each of these guidelines:

    a. Doorways and entrances to the building and office are at least 32" wide. ☐ Yes ☐ No
    b. Hallways are at least 36" wide, with sufficient room for a wheelchair to make necessary turns. ☐ Yes ☐ No
    c. There is enough room for a wheelchair user to travel from the waiting area to the treatment area. ☐ Yes ☐ No
    d. The restroom has an accessible doorway, at least 48" of clear floor space, and grab bars to allow transfer to/from a wheelchair. ☐ Yes ☐ No
    e. The building or office is accessible by more than stairs or a steep slope. ☐ Yes ☐ No
    f. If the building has parking facilities, there are parking spaces reserved for people with disabilities. ☐ Yes ☐ No

14. Has your dental office completed Cultural Competency Training? ☐ Yes ☐ No
15. Languages spoken other than English:

    Dentist's language(s) other than English: _____

    Official medical interpreter language(s) other than English: _____

    Language(s) spoken by staff other than English: _____

Compliance with state and federal regulations requires Delta Dental to periodically verify the accuracy of dentist information in our directories. Please provide your contact information in case we need to clarify any statements or data before updating our online dentist directory.

Practice location name: _____ Address: _____

City: _____ State: _____ ZIP: _____

Contact person's name:	Practice manager:
Telephone number: ( )	Telephone number: ( )
Email:	Email:

☐ I am new to Delta Dental. My practice information is indicated on this form. (Please include your signed Contract Agreement packet.)

☐ I am currently contracted with Delta Dental. Update my directory listing as indicated on this form.

☐ I reviewed my online directory entry at deltadentalins.com and attest that my practice information is accurate in Delta Dental's online directory. No changes are necessary.

☐ I attest that the dentist(s) listed below no longer treat patients nor submit claims from this location as of the date indicated.

Dentists no longer at this location (first and last names)	License number	Date

(Delta Dental will inactivate the network status at the location for dentists listed above. If necessary, use an additional sheet of paper to list more dentists. Please don't use this form to add new dentists.)

By signing below, I attest that I am authorized to represent that the information entered on this form is correct.

_____ _____ _____

Print name and title | Signature | Date

Please return this form by email or fax:

California:

- **Scan and email to: CAProviderDirectory@delta.org**
- Or, fax to: 916-858-4826

All other regions:

- **Scan and email to: Pdirectory2@delta.org**
- Or, fax to:
  - Delta Dental Insurance Company (AL, FL, GA, LA, MS, MT, NV, TX, UT) — 770-641-5395
  - Delta Dental of Pennsylvania (DC, DE, MD, NY, PA, WV) — 717-774-1770

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National Provider Identifier

Here are some guidelines and basic information about the National Provider Identifier (NPI) regulations and requirements.

ABOUT THE NPI

Standardized identifiers help reduce costs and simplify health care transactions throughout the industry. NPIs are 10-digit numbers that are unique to each health care provider or organization, and are required by HIPAA for electronic transactions.

In addition, your NPI:

- Is made up of random numbers. It contains no coded information about you or your organization.
- Is permanent. It does not change or expire.
- Does not replace social security numbers, DEA numbers, taxpayer ID numbers, taxonomy (specialty) numbers or state license numbers.
- Is issued by the government through a third-party group, the National Plan & Provider Enumeration System (NPPES). The NPPES processes all applications and assigns NPIs.

WHO NEEDS AN NPI?

If you answer "yes" to any one of the following questions, you are considered a "covered entity" under the NPI standard and are required by federal law to obtain an NPI.

- ☐ Do you submit claims electronically?
- ☐ Do you use a clearinghouse?
- ☐ Do you submit claims attachments electronically?
- ☐ Do you use the Internet to verify eligibility and benefits or check on the status of claims?

DO YOU NEED TYPE 1, TYPE 2 OR BOTH?

Type 1 is for individual health care providers, such as dentists and hygienists. This is the only type of NPI you need if you receive payments in your name and social security number as a solo practitioner.

Type 2 if for group practices, incorporated practices, clinics or other business entities that are paid in their business or corporate name, or under their employer identification number (EIN).

On claims, the Type 2 NPI identifies the billing entity (payee) and may be submitted in conjunction with a Type 1 NPI to identify the treating dentist.

Dental office configuration	Type of NPI needed	
	Type 1 Each dentist	Type 2 Each practice
Solo practitioner	•	
Individual dentist at one practice location	•	•
Multiple dentists at one practice location	•	•
Multiple dentists at multiple practices	•	•

THE APPLICATION PROCESS

1. Visit http://nppes.cms.hhs.gov.
2. Complete the application and follow instructions to submit either online or by mail. Faxes are not accepted.
3. After confirmation of receipt, you should receive your NPI via email within one to five business days if you submitted the application online. Mailed applications may require up to 20 days to process.

REPORT YOUR NPIs TO DELTA DENTAL

Email the treating dentist's NPI (Type 1) and the billing dentist/dental entity's NPI (Type 2), if they are different, to us at npi@delta.org. Include your name, practice name, address and license number. Simply submitting NPIs on claims will not ensure that they are entered into our system.

Use new claim forms that accommodate the NPI. This might require a software upgrade.

If any data related to your NPI changes, you are responsible for submitting an update to the NPPES within 30 days of the change. Examples include a name or address change.

HELP WITH APPLICATIONS

The NPI Enumerator is responsible for assisting providers with NPI applications and updating their information in the NPPES. The NPI Enumerator may be contacted as follows:

Email:
customerservice@npienumerator.com

Telephone:
800-465-3203; 800-692-2326 (NPI TTY)

Mail:
NPI Enumerator, PO Box 6059, Fargo, ND 58108-6059

FOR MORE INFORMATION

U.S. Department of Health & Human Services:
https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

WE KEEP YOU SMILING®

OUR MISSION

To advance dental health and access through exceptional dental benefits service, technology and professional support.

The information provided in this document is for educational purposes only and should not be interpreted as legal advice. Dentists are encouraged to seek their own legal advice about how the NPI pertains to their practices and circumstances.

Delta Dental of California, Delta Dental of Delaware, Inc., Delta Dental of the District of Columbia, Delta Dental of New York, Inc., Delta Dental of Pennsylvania (Maryland), Delta Dental of West Virginia, Inc., and Delta Dental Insurance Company (Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas, Utah).

All of our companies are members, or affiliates of members, of the Delta Dental Plans Association (deltadental.com).

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DELTA DENTAL®

Notification of Application Acceptance

1. Notification and claims

A "Welcome" letter will be sent to you when your contract is processed. Until then, you are considered out-of-network (non-participating) at the location(s) entered in the Agreement. During the "out-of-network" period, claims will be processed and paid according to the out-ofnetwork benefit provisions in patients' plans and paid to the patient.

2. Effective date

The Agreement/contract effective date is the date that the Agreement is finalized in our system. This date will be included in the letter you will receive from us. The Agreement effective date cannot be made retroactive.

3. Dentist Handbook

For a copy of the current Handbook and By Laws, log in to (or register for) your online account at deltadentalins.com and use the Reference Library.

4. Questions?

Please see our Dental Office Support Guide at deltadentalins.com/dentists or contact Provider Concierge at 800-592-0156.

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