

MetLife  
Preferred Dentist  
Program

Application Booklet



**DENTAL SERVICES AGREEMENT**  
**("Agreement")**  
by and between  
Metropolitan Life Insurance Company  
200 Park Avenue, New York, New York 10166  
**("Metropolitan")** and

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("Dentist")

and located at:

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<i>Number</i>	<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
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**1. RECITALS.**

WHEREAS, Metropolitan insures and/or administers employee welfare benefit plans for employers, insurers, health maintenance organizations or other groups of individuals ("Plan Sponsors") which extend dental benefits ("Plans") to employees and their dependents entitled to receive such dental benefits under the terms of the Plan ("Eligible Persons");

WHEREAS, Dentist maintains the requisite licensing and desires to provide those dental services usually and customarily rendered ("Dental Services") to Eligible Persons;

WHEREAS, Metropolitan wishes to obligate Dentist to provide Dental Services to Eligible Persons, in exchange for which Dentist is obligated to accept the fees set forth herein;

NOW, THEREFORE, in consideration of the mutual covenants contained herein, the parties agree as follows:

**2. PROVISION OF DENTAL SERVICES.**

Dentist will provide Dental Services to all Eligible Persons in accordance with the terms of this Agreement and pursuant to the terms of the applicable Plan.

**3. PAYMENT.**

For all Dental Services rendered to Eligible Persons, Dentist agrees to accept as payment in full reimbursement up to the allowance specified for the procedures listed in the Table of Maximum Allowable Charges, which is provided by Metropolitan to Dentist either prior to or upon the execution of this Agreement. These allowances represent the total payment receivable from Metropolitan and Eligible Persons. For procedures not listed in the Table of Maximum Allowable Charges, Dentist agrees to accept payment in an amount determined by Metropolitan to be comparable to listed procedures of similar difficulty and technique.

Metropolitan or its delegates shall be permitted to obtain reimbursement for overpayments made to Dentist by offsetting such monies against future payments due.

Metropolitan may modify the payment provisions set forth herein solely by giving Dentist sixty (60) days prior written notice of such modification.

**4. CO-PAYMENT, CO-INSURANCE OR DEDUCTIBLE.**

Dentist hereby agrees that in no event, including, but not limited to non-payment by Metropolitan as the insurer or administrator of a benefit plan, Metropolitan's insolvency or breach of this Agreement, shall Dentist bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person or Persons other than Metropolitan acting on behalf of an Eligible Person for services provided pursuant to this Agreement. This provision shall not prohibit Dentist from collecting the applicable co-payment, co-insurance or deductible amounts payable by Eligible Person, which Dentist is obligated to collect and agrees not to waive.

Dentist further agrees that (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Eligible Persons, and that (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Dentist and Eligible Person or Persons acting on their behalf.

Any modifications, addition, or deletion to the provisions of this Section 4 shall become effective on a date no earlier than 15 days after the appropriate state commissioner of insurance has received written notice of such proposed changes, if required.

**5. CLAIMS PROCESSING.**

Dentist agrees to submit complete claims to Metropolitan, in a manner mutually agreed upon by Metropolitan and Dentist, within thirty (30) days of the date on which such Dental Services were rendered. Dentist understands and agrees that Metropolitan's payment obligation extends only to complete, valid claims submitted in a timely fashion as set forth herein. Claims can be submitted via electronic submission or hard copy, however, electronic transmission is the preferred method of claim submission.

**6. NON-LIABILITY.**

Metropolitan shall not be liable for any claim, injury, demand or judgment, arising out of or resulting from the intentional or negligent acts or omissions of Dentist, his/her employees, agents or assigns in the course of rendering Dental Services to Eligible Persons pursuant to this Agreement. Dentist will indemnify and hold Metropolitan, its officers, assigns and delegates, harmless against any and all such claims and demands.

Dentist shall not be liable for any claim, injury, demand or judgement arising out of or resulting from the intentional or negligent acts or omissions of Metropolitan, its employees, agents or assigns in the course of its administration of this Agreement. Metropolitan will indemnify and hold Dentist harmless against any and all such claims or demands.

**7. ADVERTISING AND PROMOTION CONTROL.**

Metropolitan reserves the right to and control of the use of the corporate and trade name "Metropolitan Life Insurance Company" and parts thereof, including the trade name "MetLife PDP" and all symbols and service marks presently existing or hereinafter established. Dentist will not use any of the foregoing in advertising or promotional materials or in any other manner without the prior written consent of Metropolitan and will cease all authorized uses immediately upon the termination of this Agreement. In addition, Metropolitan shall be permitted to market alternate types of benefit plans, which may or may not have a different trade name, which would be applicable to this Agreement.

**8. ELIGIBILITY AND BENEFIT DETERMINATIONS.**

The identity of Plan Sponsors to whom this Agreement applies shall be communicated to Dentist by Metropolitan via Plan Sponsor Lists, which shall be considered an integral part of this Agreement and shall be subject to modification by Metropolitan, in its sole discretion, at any time. Dentist may elect to verify eligibility and access benefit information relating to Eligible Persons, including but not limited to limitations and exclusions of Dental Services and applicable copayment, coinsurance or deductible information by calling Metropolitan.

**9. INSPECTION OF RECORDS.**

Metropolitan or its duly authorized agents and delegates shall have the right at reasonable intervals and during regular business hours of Dentist to audit all business and financial records and dental files of Dentist which are relevant to this Agreement, as deemed necessary by Metropolitan or its delegate to assure compliance with the terms of this Agreement. Dentist agrees to maintain the confidentiality of all dental records relating to Eligible Persons and to retain such records as required by law.

**10. TERM OF AGREEMENT - TERMINATION.**

*This Agreement shall be effective on the Effective Date set forth herein and shall remain in full force and effect until terminated by either party, without cause, effective upon at least ninety (90) days prior written notice to the other.*

*Metropolitan reserves the right to terminate, effective upon receipt of written notice by Dentist, should Dentist cease to be licensed to practice dentistry in the state of his/her practice, should Dentist fail to meet Metropolitan's retention, utilization management, quality improvement or administrative criteria, or for violation of this Agreement by Dentist or for other good cause.*

**11. ASSIGNMENT.**

*Metropolitan may, at any time, assign this Agreement or any of its rights, or delegate any of its duties or obligations in whole or part set forth herein, upon prior notice to Dentist, to any of its affiliated companies or any other corporate entity.*

**12. LIABILITY INSURANCE.**

*Dentist agrees to procure and maintain policies of general and professional liability insurance in amounts not less than \$200,000 per occurrence and \$600,000 annual aggregate, or as otherwise required by Metropolitan, to insure it and its employees against any claim or claims for damages arising by reason of personal injury or death caused directly or indirectly in connection with the delivery of Dental Services. Evidence of such insurance shall be delivered to Metropolitan upon request.*

**13. NON-DISCRIMINATION.**

*Dentist agrees to render Dental Services to Eligible Persons in the same manner, in accordance with the same standards and within the same availability as offered to other individuals.*

**14. RESPONSIBILITY FOR DENTAL SERVICES.**

*Dentist agrees to comply and cooperate with Metropolitan's or its delegate's policies and procedures for dental management, utilization review, claims administration, quality improvement, peer review, credentialing and auditing, any and all of which may be modified by Metropolitan or its delegate upon notice to Dentist.*

*Dentist agrees that neither Metropolitan nor its delegate intervene in any way or manner with the provision of services by Dentist, it being understood and agreed that the traditional relationship between Dentist and individuals requiring Dental Services will not be disturbed by this Agreement. Dentist understands that claim determinations made by Metropolitan and determinations made in connection with utilization review are solely for purposes of determining whether Dental Services are covered under the terms of that plan and the extent to which benefit payments may be made thereunder. Accordingly, such determinations shall in no way affect the responsibility of Dentist to furnish appropriate services to individuals requiring Dental Services.*

**15. INDEPENDENT CONTRACTORS.**

*The relationship between the parties hereto is solely that of independent contractors. None of the parties hereto, nor any of their respective employees, shall be construed to be the agent, employee or representative of the other.*

**16. ENTIRE AGREEMENT.**

*This Agreement constitutes the entire understanding between the parties and shall not be modified or amended, except as permitted herein, without agreement signed by the parties. Notwithstanding the foregoing, Metropolitan may amend this Agreement, upon fifteen (15) days prior written notice to Dentist, to effectuate changes required pursuant to state or federal laws and regulations.*

**17. GOVERNING LAW.**

*This Agreement shall be governed in all respects by the Employee Retirement Income Security Act of 1974 (ERISA), if applicable, or by the laws of the State of New York and any other applicable federal and state laws or regulations.*

*IN WITNESS WHEREOF, the parties have executed and delivered this Agreement to be effective on the date set forth by Metropolitan below, which will coincide with Metropolitan's acceptance and approval of the Participating Dentist Survey Form, attached hereto.*

**Dentist Signature:** \_\_\_\_\_

**Metropolitan Life Insurance Company:** By: \_\_\_\_\_



*Dr. David Guarrera DDS  
Vice-President, Dental Products  
Effective Date: \_\_\_\_\_*

**ADDENDUM A  
TO  
DENTAL SERVICES AGREEMENT  
MEDICARE ADVANTAGE**

The following provisions are added to and made a part of the Dental Services Agreement (the "DSA") between Dentist and MetLife to cover the obligations of Dentist and MetLife regarding the provision of dental services and payment of dental benefits to Medicare Advantage Beneficiaries, as defined herein. To the degree any provisions in the Agreement conflict with the provisions in this Amendment, the provisions in this Amendment shall prevail.

1 **DEFINITIONS.** For purposes of this Addendum only:

- (a) **Center for Medicare & Medicaid Services (CMS).** The federal agency which is responsible for the administration of the Medicare programs.
- (b) **Medicare.** The term "Medicare" shall mean the Hospital Insurance Program (Part A) and the Supplemental Medical Insurance Program (Part B) established by Title XVIII of the Social Security Act, as amended.
- (c) **MMA.** "The Medicare Prescription Drug, Improvement, and Modernization Act of 2003" (MMA) that established Parts C (Medicare Managed Care) and D (Prescription Drug) of the Medicare Program.
- (d) **Medicare Advantage ("MA") Member.** A Medicare Beneficiary entitled to receive coverage for certain health care services, including any supplemental dental benefits, and who has enrolled with MA Organization and whose enrollment is confirmed by CMS.
- (e) **Medicare Advantage Organization (MA Organization).** A public or private entity organized and licensed by a State as a risk-bearing entity that is certified by CMS as meeting the MA contract requirements and with which MetLife has entered into an MA Agreement to provide insured dental benefits as part of a MA Part C plan or to administer, including the provision of a PPO network of dentists, the MA Organization's Part C dental benefits.
- (f) **MA.** The term "MA" shall mean "Medicare Advantage," which is the statutory name applicable to the federal program of prepaid health care services for Medicare Beneficiaries established by the MMA.
- (g) **MA Evidence of Coverage.** A legally binding statement of coverage, revised annually, between a MA Member and the MA Organization or an employer and the MA Organization under which a MA Member is entitled to receive coverage for certain hospital, medical, supplemental dental, and other associated health care services.
- (h) **Supplemental Dental Benefits.** Those dental benefits offered by or through a MA Organization on either a mandatory or optional basis to Medicare beneficiaries.

2 **REGULATORY OBLIGATIONS** Dentist agrees to:

- (a) Safeguard MA Member's privacy and confidentiality. 42 C.F.R. §§ 422.118.
- (b) Treat MA Members in a fair and non-discriminatory manner in the provision of and access to dental services which shall include but not be limited to, not denying, limiting or conditioning the receipt of dental services on the basis of any factor related to health status, source of payment, or in any manner in regards to access to, and the provision of, MetLife Dental Benefits. Health status includes but is not limited to (i) medical condition, including medical as well as mental illness; (ii) claims experience; (iii) receipt of health or dental services; (iv) medical or dental history; (v) genetic information; (vi) evidence of insurability, including conditions related to acts of domestic violence. 42 CFR 422.110(a). Further Dentist shall not unlawfully discriminate against any MA Member, employee or applicant for employment on the basis of race, religion, color, national origin, ancestry, physical handicap, marital status, age or sex. Dentist shall comply with state and federal non-discrimination laws and all implementing regulations, guidelines and standards as are now or may be lawfully adopted under state and federal anti-discrimination laws.
- (c) Ensure the accuracy of MA Member's dental and other records. 422.504(a)(13).

- (d) Not bill, charge, collect a deposit from, nor seek compensation, remuneration, or reimbursement from, nor have any recourse against a MA Member or their representative, for covered dental services provided including but not limited to, the non-payment by MetLife or the MA Organization, the insolvency of MetLife or the MA Organization, or breach of the DSA or any other agreement. This provision shall not apply to the collection of copayments, deductibles, co-insurance and amounts for non-covered services. 42 CFR § 504(g)(1)(i).
- (e) Hold MA Members harmless for payment of any fees that are the legal obligation of MA Organization and/or MetLife. 42 C.F.R. §§ 422.504(g)(1)(ii); 422.504(i)(3)(i).
- (f) Comply with Medicare laws, regulations, reporting requirements and CMS instructions. 42 C.F.R. § 422.504(i)(4)(v).
- (g) Cooperate in audits and inspections by CMS, the U.S. Department of Health and Human Services, the federal General Accounting Office and/or their designees. 42 C.F.R. §§ 422.504(e)(2), 422.504 (i)(2)(i).
- (h) Cooperate with MetLife's information requests and provide information as requested. 42 C.F.R. § 422.504(e).
- (i) Maintain all records relating to this contract for a minimum of ten (10) years. 42 C.F.R. § 504(d).
- (j) Comply with MA Organization's Policies and Procedures as disclosed in writing to the Dentist by MetLife.
- (k) Immediately inform MetLife, in writing, if the Dentist, or if a group practice, any of the Dentists in the group practice, is debarred, excluded, suspended, or otherwise prohibited from participating in federal health care programs. Dentist shall not contract with, with or without compensation, any person or entity which has been debarred, excluded, suspended or otherwise prohibited from participating in federal health care programs. Without limiting the termination provisions of the DSA, MetLife has the right to terminate the DSA immediately upon notice from Dentist or any other entity or person that Dentist has been disbarred, excluded, suspended or otherwise prohibited from participation in any federal health program.
- (l) Assure that any of its employees, delegates, assignees, agents or subcontractors comply with this paragraph 2. 42 C.F.R. 504(i)(3)(iii).
- (m) Comply with all federal statutes and regulations designed to prevent fraud, waste, and abuse, including without limitation applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 *et seq.*), the Anti-Kickback statute (42 U.S.C. § 1320a-7b(b)), the Anti-Influencing statute (42 U.S.C. § 1320a-7a(a)(5)), 42 C.F.R. § 422.504(h)(1).

3 **METLIFE OBLIGATIONS.** MetLife hereby agrees to:

- (a) Adhere to CMS Prompt Claims Payment Standards by processing clean claims submitted by Dentist and all other claims within the statutory periods established by the Medicare laws. 42 C.F.R. § 422.520 (b).
- (b) Inform Dentist of changes in Medicare Advantage rules which affect Dentist.
- (c) Process appropriately filed dentist complaints or grievances in accordance with the Medicare Advantage program. For purposes of this subparagraph, these complaints and grievances are referred to as "provider" complaints or grievances as those terms are defined by Medicare Part C.

4 **AMENDMENT OF ADDENDUM.** This Medicare Addendum will automatically amend to include terms and conditions necessary to implement additional contract terms required by CMS, unless either Party elects to terminate the DSA and this Medicare Addendum because the additional contract terms required by CMS may have a material adverse effect upon the Party electing to terminate and the Parties are unable to adjust seasonably the Agreement in a mutually satisfactory manner to resolve the material adverse effect. A Party may effect its election to terminate by giving the other Party written notice of such termination within forty-five (45) days after CMS's instruction to implement such additional required contract terms. 42 C.F.R. § 422.504(j).

5 **EFFECTIVE DATE.** This Addendum is effective as of the effective date of the DSA.

## Request for Taxpayer Identification Number and Certification

**Give form to the requester. Do not send to the IRS.**

<b>Print or type See Specific Instructions on page 2.</b>	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	List account number(s) here (optional)	

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a “saving clause.” Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called “backup withholding.” Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the “Name” line. You may enter your business, trade, or “doing business as (DBA)” name on the “Business name” line.

**Limited liability company (LLC).** Check the “Limited liability company” box only and enter the appropriate code for the tax classification (“D” for disregarded entity, “C” for corporation, “P” for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner’s name on the “Name” line. Enter the LLC’s name on the “Business name” line.

For an LLC classified as a partnership or a corporation, enter the LLC’s name on the “Name” line and any business, trade, or DBA name on the “Business name” line.

**Other entities.** Enter your business name as shown on required federal tax documents on the “Name” line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the “Business name” line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the “Exempt payee” box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
2. The United States or any of its agencies or instrumentalities,
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,
7. A foreign central bank of issue,
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
9. A futures commission merchant registered with the Commodity Futures Trading Commission,
10. A real estate investment trust,
11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
12. A common trust fund operated by a bank under section 584(a),
13. A financial institution,
14. A middleman known in the investment community as a nominee or custodian, or
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt payees 1 through 7

<sup>1</sup> See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup> However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.ssa.gov](http://www.ssa.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses](http://www.irs.gov/businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting [www.irs.gov](http://www.irs.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

## Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

### Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: [spam@uce.gov](mailto:spam@uce.gov) or contact them at [www.consumer.gov/idtheft](http://www.consumer.gov/idtheft) or 1-877-IDTHEFT(438-4338).

Visit the IRS website at [www.irs.gov](http://www.irs.gov) to learn more about identity theft and how to reduce your risk.

## What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>1</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

## Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

# Participating Dentist Survey Form

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
(For Identification Purposes Only)

Date of Birth \_\_\_\_\_ Gender: Male\_\_ Female\_\_ Degree: DDS\_\_ DMD\_\_  
mm/dd/yyyy

Individual NPI \_\_\_\_\_

State Dental License Registration # \_\_\_\_\_ Expiration Date \_\_\_\_\_  
(Copy Must be Included with Application)

If you have a license, or ever had a license to practice in any other state, please list state(s) \_\_\_\_\_

Do you prescribe drugs? Yes\_\_ No\_\_ If no, please explain \_\_\_\_\_

Federal DEA License Registration # \_\_\_\_\_ DEA Expiration \_\_\_\_\_  
(Copy Must be Included with Application)

Dental School \_\_\_\_\_

Year Graduated \_\_\_\_\_ Years in Practice \_\_\_\_\_

Specialty Endodontist\_\_ Oral Surgeon\_\_ Orthodontist\_\_ Pedodontist\_\_  
Periodontist\_\_ Prosthodontist\_\_ Oral Pathologist\_\_ Oral Radiologist\_\_

Specialty Training Institute \_\_\_\_\_ Completion Date \_\_\_\_\_  
(Copy of Specialty Certificate Must be Included to Process Your Application)

Board Certified Yes\_\_ No\_\_ Year \_\_\_\_\_ Specialty: \_\_\_\_\_

If you are an Oral Surgeon: Do you have hospital privileges? Yes\_\_ No\_\_

Hospital name \_\_\_\_\_ Telephone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Do you file claims electronically? Yes\_\_ No\_\_

Preferred method of receiving printed communication materials:

United States Postal Service \_\_\_\_ Email (PDF) \_\_\_\_

Office email address \_\_\_\_\_ Web URL \_\_\_\_\_

Name of Current Professional Liability Carrier \_\_\_\_\_

Policy # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Policy Limits Each \_\_\_\_\_ Aggregate \_\_\_\_\_

(Include Copy of Policy Declaration Page Showing Professional Liability/Malpractice Coverage Amount & Expiration Date)

**Please answer the following questions. (And if Yes, please submit dates, circumstances and dispositions on a separate sheet.)**

	<u>YES</u>	<u>NO</u>
Have any malpractice claims or suits been filed against you within the past 10 years? (If claim or suit was resolved by settlement please forward appropriate information.)	-	-
Has any information pertaining to you ever been reported to the National Practitioner Data Bank? (If yes, include a copy of report.)	-	-
Has your professional license in any state ever been denied, revoked, limited, suspended, put on probation reprimanded or voluntarily relinquished?	-	-
Has your DEA registration ever been denied, revoked, limited, suspended or voluntarily relinquished?	-	-
Have you ever been convicted of a criminal offense?	-	-
Have you ever had, or been advised to seek treatment for, any chemical dependency or substance abuse condition?	-	-
Have you ever been disciplined by any State Board of Dental Examiners or any Misconduct Board?	-	-
Have you ever voluntarily relinquished your participation or been denied, expelled or suspended from participating in any state or federal program including Medicare or Medicaid?	-	-
Have you ever been refused membership or has your membership ever been revoked, suspended or limited on a health care facility professional staff or in a managed care plan?	-	-
Have you ever been subject to any Peer Review action?	-	-
Have you ever had or do you presently have any mental condition, physical condition (such as an infectious disease) or health status that interferes or could interfere with your ability to practice dentistry or in any way endangers or could endanger your patients?	-	-

**Does your office:**

	<u>YES</u>	<u>NO</u>
Utilize infection control and barrier techniques according to OSHA/CDC guideline standards for blood borne pathogens and infectious waste?	-	-
Clean and heat sterilize high-speed, air driven hand pieces and prophylaxis angles between each patient visit?	-	-
Comply with OSHA requirements with respect to hazardous waste materials?	-	-
Comply with federal, state and local laws in the conduct of your profession including those prohibiting discrimination against the disabled?	-	-
Have 24-hour emergency coverage or have alternate arrangements for emergency care for your patients? Explain _____	-	-

I certify that the above information is correct and complete and agree to immediately notify MetLife in writing of any changes if I am accepted. I understand that MetLife has complete discretion in accepting or rejecting my application.

**Dentist Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
 (Signature stamp will NOT be accepted) (current within 30 days)

**Office Information Section:** Please provide this information for each location where you wish to participate.  
If you have more than 3 locations, you may use a copy of this form or a separate sheet. **Please Type or Print.**

**ADDRESS 1** Name of Office/DBA \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Tax Identification Number (IRS 1099) \_\_\_\_\_  
Name for which Tax ID# has been issued \_\_\_\_\_  
NPI Type 2 (Office) \_\_\_\_\_  
Office Hours: Mon \_\_\_\_\_ Tue \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_  
Languages spoken other than English \_\_\_\_\_  
How many dentists practice at this location? \_\_\_\_\_ Wheelchair Accessible? Yes\_\_ No\_\_  
**Billing address if different from location** \_\_\_\_\_  
\_\_\_\_\_

**ADDRESS 2** Name of Office /DBA \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Tax Identification Number (IRS 1099) \_\_\_\_\_  
Name for which Tax ID# has been issued \_\_\_\_\_  
NPI Type 2 (Office) \_\_\_\_\_  
Office Hours: Mon \_\_\_\_\_ Tue \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_  
Languages spoken other than English \_\_\_\_\_  
How many dentists practice at this location? \_\_\_\_\_ Wheelchair Accessible? Yes\_\_ No\_\_  
**Billing address if different from location** \_\_\_\_\_  
\_\_\_\_\_

**ADDRESS 3** Name of Office /DBA \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Tax Identification Number (IRS 1099) \_\_\_\_\_  
Name for which Tax ID# has been issued \_\_\_\_\_  
NPI Type 2 (Office) \_\_\_\_\_  
Office Hours: Mon \_\_\_\_\_ Tue \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_  
Languages spoken other than English \_\_\_\_\_  
How many dentists practice at this location? \_\_\_\_\_ Wheelchair Accessible? Yes\_\_ No\_\_  
**Billing address if different from location** \_\_\_\_\_  
\_\_\_\_\_

**WORK HISTORY: Check here** \_\_\_ if you have practiced in **this same location** for the **past 5 years**  
*Please use separate sheet of paper if necessary to complete 5 year history*

Practice Name, experience, residency, etc. \_\_\_\_\_

Location (City & State) \_\_\_\_\_ Start Date (mm/yyyy) \_\_\_\_\_ End Date (mm/yyyy) \_\_\_\_\_

Position Held or Description of Work \_\_\_\_\_

Practice Name, experience, residency, etc. \_\_\_\_\_

Location (City & State) \_\_\_\_\_ Start Date (mm/yyyy) \_\_\_\_\_ End Date (mm/yyyy) \_\_\_\_\_

Position Held or Description of Work \_\_\_\_\_

Practice Name, experience, residency, etc. \_\_\_\_\_

Location (City & State) \_\_\_\_\_ Start Date (mm/yyyy): \_\_\_\_\_ End Date (mm/yyyy) \_\_\_\_\_

Position Held or Description of Work \_\_\_\_\_

In order to evaluate my application for participation in and/or my continued participation in the MetLife Preferred Dentist Program, I hereby give permission to the Dental Director of MetLife or his designee, agent, or other third party entities to request from others information regarding my professional credentials and qualifications. This includes consent to contact Chief(s) of Clinical Departments of the Hospital(s) in which I have/had staff privileges, professional certification boards, State Regulatory and Licensing Departments, professional liability insurance carriers and employers.

I certify that the information provided and the answers to the questions on this application are accurate and complete. While this application is being considered, and if I am accepted, after such acceptance, I agree to inform you in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to my signing this application.

I agree that submission of this application does not constitute approval or acceptance by MetLife on its own behalf or, if applicable, as agent for one of its affiliates and grants me no rights or privileges in any MetLife program or any program of one of its affiliates until such time as I receive notice of acceptance.

**Dentist Signature X** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Signature stamp will NOT be accepted) (current within 30 days)

**Have you enclosed your:**

\_\_\_ Copy of your current state license registration, Federal DEA & Specialist Certificate, if applicable

\_\_\_ Copy of your current professional liability policy? (Minimum Limits \$200,000/\$600,000)

**NOTE:** If you are **not** using a MetLife self-addressed return envelope, please mail all documentation to the following address: **MetLife, PO Box 981282, El Paso TX 79998-1282**



# PRACTICE SELF-ASSESSMENT

INSTRUCTIONS: COMPLETION OF THIS FORM IS REQUIRED FOR PARTICIPATION IN METLIFE'S DENTAL PROGRAM. INDICATE A YES OR NO FOR EACH ITEM. PLEASE DO NOT LEAVE ANY ITEMS BLANK.

PART I - There is an expectation that the following items that promote the health and safety of patients and staff are in place: YES NO

- 1. The office has a protocol for the management of medical emergencies.  YES  NO
- 2. At least one member of the practice, currently certified in CPR, is present in the practice when patient care is being provided.  YES  NO
- 3. Portable oxygen and the capability to deliver it under positive pressure is available.  YES  NO
- 4. A device to assist ventilation alone or in conjunction with CPR is immediately available.  YES  NO
- 5. Updated medical emergency kit containing adequate medications is immediately available.  YES  NO
- 6. A designated area with facilities and operable equipment for eye washing in the event of contamination or chemical injury is available.  YES  NO
- 7. There is easy access for the physically challenged.  YES  NO
- 8. An x-ray duplicator or double packet films or digital radiography is available.  YES  NO

PART II - The following expectations relate to various aspects of patient care: YES NO

- 1. There is a written protocol for the placement of "medical alerts" in patient records.  YES  NO
- 2. The patient record includes a plan to manage a medical condition(s) that warrant a medical alert.  YES  NO
- 3. Radiation protection for patients is provided.  YES  NO
- 4. For new patients, films are taken after assessment by the dentist.  YES  NO
- 5. The name of the patient's physician or "none" is noted in the patient record.  YES  NO
- 6. The patient's record includes a medical history that is updated and documented at each appointment.  YES  NO
- 7. The patient's record includes a dental history.  YES  NO
- 8. An intra oral cancer screening examination is performed and documented at a minimum annually.  YES  NO
- 9. A head and neck examination is performed and documented at a minimum annually.  YES  NO
- 10. Complete progress notes are found in all patient records.  YES  NO

- 11. A general consent for treatment is obtained prior to the initial examination.....
- 12. There is documentation that informed consent is obtained for all invasive procedures .....
- 13. Written pre-operative instructions are provided for patients at the appropriate time.....
- 14. Written post-operative instructions are provided for patients at the appropriate time. ....
- 15. There is a system for dental emergency coverage .....
- 16. An automated external defibrillator (AED) is operational and readily available.....
- 17. Blood pressure (BP) is taken and documented annually or as frequently as required by the patient's medical history.....
- 18. The patient's risk for periodontal disease is assessed and recorded.....
- 19. The patient's risk for caries is assessed and recorded.....
- 20. An amalgam separator is used to remove amalgam waste particles from office waste water. ....

**PART III - Are the following procedures that relate to the sterilization and disinfection of instruments and equipment and the management of sources of other potentially infectious material (OPIM) used routinely:**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Instruments are cleaned before sterilization .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. All dental unit waterlines flushed a minimum of twenty seconds after each patient.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Dental unit water/waterlines are tested for biofilm on a regular basis, and it is documented .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Impressions are disinfected before poured.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. When laboratory cases are sent off site, they are disinfected.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Disposable sharps are placed in puncture resistant containers. Containers should be located in close proximity to where they are used.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Blood spills or other potentially infectious materials (OPIM) are cleaned and the surface decontaminated with an EPA registered disinfectant. .... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Biological indicator (spore test) is done at least weekly for all sterilizers in use .....   | <input type="checkbox"/> | <input type="checkbox"/> |

**PART IV - It is expected that the following sources of cross-contamination are disinfected after each patient or are protected by disposable coverings that are changed after each patient:**

YES NO

- 1. Light handles .....
- 2. All hand operated units/chair switches and controls.....
- 3. Drawer handles.....
- 4. Surfaces of all work areas .....
- 5. X-ray switches and controls.....
- 6. X-ray head .....
- 7. Barrier protection is used in work areas (counters, trays, etc.) to cover items stored and not currently being used, yet exposed to aerosol contamination .....
- 8. Radiographic equipment and radiographic film/sensors are protected by disposable coverings or disinfected for each patient, such that cross contamination is prevented.....
- 9. Contaminated barrier protection is removed while dental healthcare personnel (DHCP) is still gloved .....
- 10. After performing hand hygiene, DHCP places clean barrier protection before the next patient. ....

**PART V - The following expectations relate to infection controls in place and used routinely by staff as appropriate.**

YES NO

- 1. Personal protective equipment (PPE) that covers personal clothing and skin (e.g. forearms), with the potential to become contaminated with blood, saliva or OPIM is routinely used. ....
- 2. Gloves appropriate to the treatment being provided are routinely used. ....
- 3. A face mask is worn by all DHCP during patient treatment.....
- 4. Eye protection is used by all DHCP during procedures likely to produce spattering of blood or other body fluids. ....
- 5. Hands are washed or alcohol based rub is used between patients before donning new gloves.....
- 6. Personal protective garments that are worn during patient treatment are removed before leaving the office.....

7. Personal protective garments that are worn during patient treatment are laundered or disposed of onsite or sent out to a laundry service consistent with guidelines for the handling of contaminated garments.....  YES  NO

**PART VI - The following expectations relate to the prevention and management of infections that have the potential to be contracted during the delivery of oral health care:**

- 1. Hepatitis B vaccine has been received or offered to all DHCP with potential occupational exposure to blood or other potentially infectious materials (OPIM) as part of a comprehensive immunization program. ....  YES  NO
- 2. Clinical personnel receive infection control training at initial employment.....  YES  NO
- 3. Personnel subject to occupational exposure receive infection control training at a minimum annually .....  YES  NO
- 4. Post exposure management, including referral arrangements protocol are available to all DHCP .....  YES  NO
- 5. Standard Precautions (formerly referred to as Universal Precautions) are routinely applied .....  YES  NO

**PART VII - To be completed only by general practitioners for patients for whom you provide ongoing care. Do your records include:**

- 1. The patient record includes a description of pre-existing dental treatment. ....
- 2. The patient record contains a treatment plan.....

With my signature, I attest to the accuracy of the responses provided in this survey and indicate my willingness to correct all deficiencies and be in compliance within 365 days.

Dentist Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Tax Id Number \_\_\_\_\_ National Provider Id Number \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

Practice Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_