Simple Steps to Join LIBERTY Dental Plan's Network of Providers

Owner – Per Facility/Location

(All Facility/Location documents signed by Owner/CEO, CFO, VP, or Dental Director)

- ❑ Facility Application Per Location
  (One set of documents per location)
- ❑ Provider Agreement
  (Must be signed by authorized signatory – Owner, CEO, VP, etc.)
- ❑ Medicaid and/or Medicare Addenda
  (Must be signed by authorized signatory if applicable)
- ❑ Fee Schedule Addenda
  (Must be signed by authorized signatory)
- ❑ W-9
  (Must use the address registered with the IRS as your corporate billing address for multiple locations with the same tax ID #. Must be signed by authorized signatory.)
- ❑ Electronic Fund Transfer Form
  (If applicable)
- ❑ Provider Compliance Attestation

Owner & Associates

- ❑ Provider Credentialing Application
  (One credentialing application must be completed and signed for each Dentist rendering services.)
- ❑ Current Dental license
- ❑ Current Federal DEA certificate or waiver
- ❑ Current malpractice insurance certificate declaration page showing professional liability
- ❑ Copy of Specialty Certificate
  (If applicable)
- ❑ Copy of internship/residency/ fellowship certificate
  (If applicable)
- ❑ Copy of Board Certification
  (If applicable)

Services rendered prior to the receipt of the Welcome Letter reflecting an Effective Date will be denied.

The items listed above are required and must accompany this application. Failure to do so may delay the processing of your application. Please email the completed application to prnational@libertydentalplan.com or mail to:

LIBERTY Dental Plan
PO Box 26110
Santa Ana, CA 92799

If you have any questions regarding the contracting process, please contact Professional Relations at (800) 268-9012.

FACILITY APPLICATION *(Complete one application per facility)*

Facility Information

PRACTICE NAME (DBA): _____

PRACTICE ADDRESS: _____
Street Address *Suite/Unit #*

_____
City *State* *Zip* *County*

TELEPHONE #: ( ) _____ **Fax #:** ( ) _____

EMERGENCY #: _____ **EMAIL ADDRESS:** _____

INDIVIDUAL NPI #: _____ **ORGANIZATIONAL NPI #:** _____
(if applicable)

TAX PAYOR IDENTIFICATION (TIN): _____ **CONTACT NAME:** _____

ALTERNATE MAILING ADDRESS: *(if different from practice address)*

☐ PAYMENT REMITTANCE ☐ CORRESPONDENCE

_____
Street Address *Suite/Unit #*

_____
City *State* *ZIP Code*

LANGUAGES SPOKEN: _____

RECALL METHOD USED: _____

PRIMARY DENTIST:	_____	☐ **DDS**	☐ **DMD**	☐ **Other**	_____
ASSOCIATE DENTIST:	_____	☐ **DDS**	☐ **DMD**	☐ **Other**	_____
ASSOCIATE DENTIST:	_____	☐ **DDS**	☐ **DMD**	☐ **Other**	_____
ASSOCIATE DENTIST:	_____	☐ **DDS**	☐ **DMD**	☐ **Other**	_____

Please check if this facility is designated as any one of the following:

☐ **(FQHC)** Federally Qualified Health Center

☐ **(CHC)** Community Health Center

☐ **(IHS)** Indian Health Services

☐ **(RHC)** Rural Health Clinic

Accessibility

Does this facility have a 24 hour emergency contact system? ☐ **Yes** ☐ **No** **Special Needs** ☐ **Yes** ☐ **No**

What type of emergency contact system is used? _____

Is this facility wheelchair accessible? ☐ **Yes** ☐ **No**

Age range of patients seen? ☐ **All Ages** ☐ **0 – 21**

Minimum Treatment Age: _____ ☐ **Other:** _____

Hours of Operation

Monday		AM		PM
Tuesday		AM		PM
Wednesday		AM		PM
Thursday		AM		PM
Friday		AM		PM
Saturday		AM		PM
Sunday		AM		PM

Appointment Wait Times

Initial _____ **days**

Hygiene _____ **days**

Routine _____ **days**

Lobby Wait Time _____ **minutes**

LIBERTY Dental Plan
TEXAS PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT (the "Agreement") is made and entered into by and between LIBERTY Dental, P.A., a Texas Professional Association ("LIBERTY"), and **[LEGAL NAME OF DENTAL OFFICE]**: _____ ("Dental Office"), a **[CHECK ONE]:** ☐ ***individual practice*** ☐ ***partnership*** ☐ ***professional corporation*** ☐ ***other***:_____, effective as of the date specified by LIBERTY on the signature page (the "Effective Date"). LIBERTY and Dental Office may each be referred to as a "Party" and Dental Office together, may be referred to as the "the Parties."

WITNESSETH:

WHEREAS, LIBERTY has organized as a professional association under the laws of the State of Texas and desires to make contractual arrangements for its Members (hereinafter defined) under which Dental Office (hereinafter defined) agrees to furnish dental and related services to Members; and

WHEREAS, Dental Office is willing to enter into this Agreement with LIBERTY and furnish dental and related services to Members of LIBERTY upon the terms and conditions herein contained;

NOW, THEREFORE, in consideration of the premises and the mutual terms, covenants and conditions hereinafter set forth, the parties mutually agree as follows:

This Agreement, together with the Provider Application Form and the Provider Reference Guide, constitute the entire agreement of the parties.

Certain terms have a specific meaning in this Agreement, and are set forth below.

ARTICLE I - DEFINITIONS

1.1 **Clean Claim** shall mean a claim which can be processed immediately and meets all applicable requirements set forth in the Provider Reference Guide, which Guide is incorporated into this Agreement by this reference.

1.2 **Continuity of Care** shall mean the obligation of LIBERTY to continue to reimburse a provider for services, which would have been covered had the Agreement not been terminated, provided to a Member beyond the termination date where certain "Special Circumstances," as defined herein, are present. **Special Circumstances** means a condition in which the treating provider reasonably believes that discontinuing care by the provider could cause harm to a Member who has a special circumstance, including a Member with a disability, acute condition, life threatening illness, or who is past the twenty-forth (24th) week of pregnancy.

1.3 **Cost Sharing** means any applicable Member coinsurance, copayment or deductible charged by the Dental Office to a Member which the Member is solely responsible for under the terms of this Agreement as set forth in the applicable Plan Description.

1.4 **Covered Services** shall mean those Services which are covered by the applicable Dental Plan (dental benefits, services, treatment and supplies that the Member is entitled to receive under the applicable Dental Plan(s), as set forth in the Plan Description.

1.5 **Dental Director** shall mean the individual or group of individuals appointed by LIBERTY to maintain professional standards for the dentists contracting with LIBERTY.

1.6 **Dental Office** means the individual dentists or dental practice (whether a partnership, professional corporation or other business entity) named in the above preamble and on the signature page of this Agreement. As further described in Section 2.2 ("Dental Office Agents"), "Dental Office" shall be construed to include, with respect to all restrictions upon and obligations of Dental Office under this Agreement, all dentists of Dental Office that have been contracted, or approved by, LIBERTY. Only those Dental Office locations and Dental Office dentists approved by LIBERTY shall be able to perform services under this Agreement and be eligible for compensation hereunder. Each Dental Office dentist shall be duly licensed to practice dentistry by the Board of Dental Examiners, State of Texas.

1.7 **Dental Office's Usual and Customary Rates** (Dental Office U&C) shall mean the normal rates charged by Dental Office for services.

1.8 **Dental Plan(s)** shall mean various plans for Payors outlining terms of coverage as provided by LIBERTY.

1.9 **LIBERTY Agreement** shall mean the agreements entered into by LIBERTY with Payors setting forth the terms on which Dental Office in the LIBERTY network will render Services. It is understood by the parties that LIBERTY is not an insurance company and is not paying or assuring reimbursement or indemnification or otherwise acting as an insurance company under this Agreement.

1.10 **LIBERTY Dental, P.A.** (herein referred to as: "LIBERTY") shall mean a Texas corporation operating pursuant to the Act which arranges for single service dental health care services to Members that are set forth herein. Should LIBERTY elect to contract the administration of its services to a third party, the references to LIBERTY can mean the third party administrator.

1.11 **LIBERTY Fee Schedule Amounts** shall mean lower of Dental Office's usual, customary and reasonable fees or the fees set forth in Exhibit A.

1.12 **Member** shall mean an individual participating in the Dental Plan(s).

1.13 **Payors** shall mean self-insured employers, unions or licensed insurance companies, which (i) provide dental care benefits to Members, and (ii) have entered into a LIBERTY Agreement.

1.14 **Plan Description** means the evidence of coverage and summary of benefits issued to Member by LIBERTY that describes Covered Services, exclusions and limitations, and Cost Sharing.

1.15 **Services** shall mean those dental services which Dental Office is licensed to render and customarily provides.

ARTICLE II- RELATIONSHIP OF PARTIES

2.1 **Independent Contractors:** LIBERTY and Dental Office are separate and independent entities. Dental Office shall be deemed an independent contractor, and not an employee, agent, joint venturer or partner of LIBERTY, within the meaning of all federal, state and local laws and regulations governing employment insurance, workers' compensation, labor and taxes and any other applicable laws and regulations. Nothing in this Agreement, nor any act or conduct by LIBERTY, shall be interpreted or construed as making Dental Office or any Dental Office Agents an agent, partner or joint venture or LIBERTY or as creating or establishing an employer-employee relationship between LIBERTY and Dental Office (or Dental Office Agents). LIBERTY shall not be liable for withholding taxes respecting Dental Office. For tax purposes, Dental Office shall, as LIBERTY deems necessary, receive a Form 1099 or other appropriate tax-related documents and Dental Office shall be responsible for its own taxes associated with its performance of the services hereunder and receipt of payments pursuant to this Agreement. Dental Office shall not, by reason of this Agreement, acquire any benefits, privileges or rights under any benefit plan operated by LIBERTY for the benefit of its employees, including, without limitation, any pension or profit-sharing plans or any plans, coverages or benefits providing workers' compensation, medical, dental, disability or life insurance protection. Dental Office agrees and acknowledges that Dental Office is not authorized to enter into any contract or assume any obligation on behalf of LIBERTY without the prior written consent of LIBERTY. The Parties acknowledge and agree that Dental Office shall be solely responsible for dental advice and the provision of services (or failure to provide services) to Members and that LIBERTY shall not be liable for any act or omission by Dental Office or by Dental Office Agents.

2.2 **Dental Office Agents**: All of the restrictions on and obligations of Dental Office set forth in this Agreement shall equally apply to any dentist of Dental Office performing services under this Agreement and to any employee or assistant (or any other person acting at the direction or under the control) of Dental Office (collectively, "Dental Office Agents"), whether or not such restrictions or obligations expressly mention Dental Office Agents. Dental Office shall ensure that all of its Dental Office Agents comply with all such restrictions and obligations set forth in this Agreement, and Dental Office acknowledges and agrees that it is solely responsible for all of its Dental Office Agents' compliance.

ARTICLE III- DUTIES OF DENTAL OFFICE

3.1 **Dental Office agrees to:**

3.1.1 Participate in the Dental Plan(s), as provided by LIBERTY and in accordance with applicable fee schedules, and provide the applicable Covered Services to all Members selecting Dental Office. Dental Office acknowledges and agrees that LIBERTY may delete, add to, or otherwise amend or modify its Dental Plans, and that such deletions, additions, amendments and modifications will be deemed agreed to by Dental Office and shall become part of this Agreement.

3.1.2 Render the services provided by this Agreement in a timely manner consistent with the professional and ethical standards of the American Dental Association ("ADA") and the LIBERTY Dental Director, which services shall be the best possible in light of the technology and medical knowledge which is available at the present time.

3.1.3 Conduct his/her relationship with LIBERTY and LIBERTY Members in a professional and positive manner, and not make untruthful or otherwise disparaging statements regarding his relationship with LIBERTY, LIBERTY Members or LIBERTY's business, nor conduct himself in any fashion that could be detrimental to the business of LIBERTY, as solely determined by LIBERTY.

3.1.4 Complaint Notice: Post in its offices a notice to Members regarding the process for resolving complaints with LIBERTY. This notice must include the Texas Department of Insurance toll-free telephone number for filing complaints (800-252-3439).

3.2 **Prohibited Discrimination**: Dental Office shall not unlawfully discriminate in the treatment of his/her patients by reason of sex, race, nationality, religion, health or economic status.

3.3 **Administrative**: To enable LIBERTY to implement appropriate quality assurance and utilization review programs and to comply with the provisions of the Act and rules and regulations hereunder, Dental Office shall:

3.3.1 Agree to provide to LIBERTY an accurate description of all services rendered to Members of LIBERTY on ADA Claim Forms. The forms shall be completed and submitted to LIBERTY as services are performed. Dental Office shall comply with all applicable clean claims requirements as set forth in the Provider Reference Guide; Dental Office's failure to submit a Clean Claim forfeits Dental Office's right to payment on that claim unless the failure was the result of a catastrophic event that substantially interfered with the Dental Office's normal business operations;

3.3.2 Cooperate with LIBERTY in maintaining and providing such dental, financial, administrative and other records relating to a Member as may be requested by LIBERTY. When provided to LIBERTY, these records shall maintain the confidential nature they had while in the possession of Dental Office;

3.3.3 Cooperate and participate with LIBERTY/Payor in service standards, quality assurance, peer review and audit systems, on-site inspections, and grievance procedures, as set forth by LIBERTY. Dental Office shall comply with all final determinations rendered by the peer review process or grievance procedure established by LIBERTY;

3.3.4 Cooperate with LIBERTY by providing updated copies of state licenses, DEA Controlled Substances Certificates, Texas Controlled Substances Certificates, Radiation Certifications, and Malpractice Insurance Policies as these certificates and policies renew.

3.3.5 Provide written notice to LIBERTY immediately upon any changes to the information provided to LIBERTY on the Dental Office's provider application (or the provider application of any of its Dental Office Agents, if applicable). In addition, Dental Office shall provide immediate written notice to LIBERTY of any suspension or revocation of Dental Office's licenses, certifications or qualifications, of any investigation of Dental Office by a governmental agency or division, or any litigation or other legal proceeding involving Dental Office and a Member.

3.3.6 Dental Office agrees to participate in and abide by the credentialing policies established by LIBERTY.

3.4 **Confidentiality**: Dental records of Member shall be treated as confidential in order to comply with all federal and state laws and regulations regarding the confidentiality of patient records. Dental Office agrees to maintain the confidentiality of the Member's records and enrollment information and prevent unauthorized disclosure.

3.5 **Inspection:** Dental Office agrees to allow inspection, during normal business hours, of financial books and records to the extent of its dealings with LIBERTY under this contract by LIBERTY/Payor and authorized authorities of the State of Texas. Dental Office hereby releases from liability all representatives of LIBERTY for their acts performed in good faith and without malice in connection with evaluating Dental Office's practice and hereby releases from liability any and all individuals and organizations who provide dental care-related information to LIBERTY.

3.6 **Patient Relationship:** Subject only to the quality assurance standards set forth in this Agreement and the Provider Reference Guide, the Dental Office shall be solely responsible for all dental advice and services rendered to a Member.

3.7 **Refusal of Services**: Dental Office shall have the right to refuse services to any Member who habitually has broken appointments or has behaved in a grossly discourteous manner toward Dental Office, Dental Office's employees and/or other patients. Dental Office shall immediately report to LIBERTY all such instances where Dental Office refuses services to a Member to assure continuity of care.

3.8 **Hold Harmless Clause**: A hold harmless clause is a provision, as set forth below in 3.8.1 and as required by Texas Insurance Code 843.361, in a provider agreement that obligates the provider to look only to LIBERTY and not its Members for payment for Covered Services (except as described in the evidence of coverage issued to the Member).

3.8.1 Dental Office hereby agrees that in no event, including but not limited to non-payment by LIBERTY/Payor or breach of this Agreement, shall Dental Office bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber, Member, or persons other than LIBERTY acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or Cost Sharing made in accordance with the terms of the applicable agreement between LIBERTY or Payors and the Member. The Provider further agrees that: (1) this provision shall survive the termination of this Agreement regardless of the cause giving the rise to termination and shall be construed to be for the benefit of LIBERTY'S Member, and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between provider and subscriber, Member, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the commissioner has received the written notice of such proposed changes regarding retaliation as described in Texas Insurance Code 843.281.

3.8.2 The Agreement does not prohibit Dental Office from collecting Member Cost Sharing or fees for non-covered services as long as Member has been informed in advance that services are not covered and that Member is financially responsible for any non-covered services and as long as Dental Office agrees to charge no more for such non-covered service than the LIBERTY Fee Schedule Amounts.

3.9 **Insurance**: Dental Office shall secure and maintain such policies of general and professional liability insurance as shall be necessary to insure Dental Office (and Dental Office Agents), against any liability, claim or claims for damages arising by reason of injury or death, occasioned directly or indirectly, in connection with the performance or nonperformance of any service by Dental Office or by Dental Office Agents, under this Agreement. Dental Office (and each dentist of Dental Office) shall maintain minimum coverage limits for professional liability insurance of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate. Dental Office shall also require that every dental hygienist and all appropriate dental auxiliaries employed by or contracting with Dental Office shall maintain professional liability insurance of similar limits or be named insured on the professional liability insurance of Dental Office.

3.10 **Evidence of Insurance**: Dental Office shall deliver to LIBERTY satisfactory evidence of such insurance coverage during each year of this Agreement or upon LIBERTY's request and shall further notify LIBERTY immediately of any and all substantial changes in or cancellation of said insurance coverage. The failure of Dental Office to secure and maintain such professional liability insurance shall constitute a breach of this Agreement.

3.11 **Indemnity**: LIBERTY/Payor shall not be liable for any act or omission by Dental Office or by any Dental Office Agents in connection with or arising out of the negligent performance or nonperformance of dental services by Dental Office/Dental Office Agents with regard to LIBERTY Members. For such act or omission by Dental Office, Dental Office agrees to defend, indemnify, and hold harmless LIBERTY and LIBERTY's officers, agents and employees, against and from any claims, demands, liabilities, damages, losses, suits or judgments against any or all of the parties referenced herein.

3.12 **Non-Solicitation**: Dental Office agrees that during the term of this Agreement and for the one-year (1-year) period following termination of this Agreement, Dental Office shall not solicit or otherwise approach then current Members of LIBERTY to become Members in a prepaid dental plan, preferred provider organization or any other managed dental delivery system (other than LIBERTY) to which Dental Office is a provider or has an ownership interest, nor shall Dental Office in any fashion encourage any Member to terminate from LIBERTY. LIBERTY does not otherwise intend to limit Dental Office's communications with Members with respect to the Member's condition or treatment options, the terms of the applicable dental plan as relates to Member's dental needs, the termination of this Agreement to the extent it affects the Member or the coverage of dental services that are not available in LIBERTY'S network, subject to the terms set forth in Section 7.11 of this Agreement ("Communications").

3.13 **Compliance with Laws and Regulations**: Dental Office agrees to comply with all applicable federal and state laws, rules and regulations, as may be amended from time to time.

ARTICLE IV - QUALITY ASSURANCE

4.1 **Standards**: Dental Office agrees to perform services for Members with the same professional and ethical standards of care, skill, and diligence as generally promulgated by the American Dental Association and in accordance with the policies and procedures established by the Dental Director of LIBERTY from time to time.

4.2 **Quality Assurance**: LIBERTY, in consultation with its Dental Director, shall develop, implement and maintain a Quality Management and Improvement Program, policies and procedures and service standards. Dental Office shall be bound by and comply with such policies and procedures and service standards as set forth in the LIBERTY Provider Reference Guide.

4.2.1 Radiology Equipment: If the Dental Office utilizes radiology or radiographic equipment at his facility in rendering services pursuant to this Agreement, the Dental Office shall have such equipment regularly checked by local or state health authorities or a radiation physicist to insure that such equipment is environmentally safe and technologically accurate. Any hazards identified by such inspections or at any time shall be promptly corrected. The Dental Office shall maintain equipment maintenance and calibration records and all inspection certificates or reports which shall be available for review by LIBERTY upon request.

4.3 **Clinical Laboratory**: In the event Dental Office has a need to use the services of a clinical laboratory for services rendered to a LIBERTY Member, then Dental Office shall use a Medicare Certified Independent Laboratory or Medicare Certified Hospital Laboratory.

ARTICLE V - COMPENSATION

5.1 **Applicable Dental Plans**: This Agreement will provide for compensation to Dental Office based on Dental Office's agreement to provide services to LIBERTY Members. The compensation due Dental Office will be based on each Dental Plan under this Agreement.

5.2 **Fees for Services**: In exchange for the provision of Covered Services to Members, Dental Office shall be compensated in accordance with the applicable fees set forth in Exhibit A or as set forth in the applicable compensation addendum or fee schedule provided by LIBERTY or mutually agreed upon by the Parties. Dental Office acknowledges and agrees that all such fees will be based on the current, applicable Dental Plan(s). Dental Office agrees to accept such fees and any applicable Cost Sharing as payment in full for the rendered Covered Services.

5.3 **Coordination of Benefits/Subrogation Claims**: The value of any benefits or services provided under this Agreement may be coordinated with any other type of group insurance plan or coverage under governmental programs pursuant to the requirements of the Texas Insurance Code and rules promulgated by the Texas Board of Insurance. Dental Office agrees to reasonably cooperate with LIBERTY in connection with its efforts to coordinate benefits or with respect to any subrogation claim LIBERTY may pursue.

ARTICLE VI - TERM AND TERMINATION OF AGREEMENT

6.1 **Term**: This Agreement shall be effective as of the Effective Date specified by LIBERTY on the signature page of this Agreement and shall have an initial term of three (3) years. This Agreement shall continue in effect from year to year thereafter upon each and all of the terms and conditions herein contained, unless and until terminated as hereinafter provided.

6.2 **Termination:**

6.2.1 This Agreement may be terminated with or without cause by Dental Office by written notice sent by registered or certified mail, at least ninety (90) days in advance of the proposed termination date. Dental Office's name will be removed from all future printings of LIBERTY materials, subsequent to the effective date of such notice.

6.2.2 LIBERTY may terminate this Agreement, with or without cause, by written notice at least ninety (90) days in advance of the effective date of termination, except in the case of imminent harm to patient health, action against license to practice, or fraud, in which case termination may be immediate.

6.2.3 Dental Office shall have the right to terminate this Agreement immediately in the event LIBERTY ceases to hold a certificate of authority to operate as a single health care service plan under the Act and applicable Texas law.

6.2.4 This Agreement may be terminated at any time upon the mutual agreement of the parties hereto.

6.2.5 LIBERTY may deactivate Dental Office from further Member selection if LIBERTY determines that it needs to do so to investigate Dental Office compliance with the terms of this Agreement.

6.2.6 Prior to termination, LIBERTY will provide a written explanation to Dental Office of the reason(s), if any, for termination. Upon request and before the effective date of the termination (but not more than thirty (30) days following receipt of the notice of termination), Dental Office shall be entitled to a review of LIBERTY's proposed termination by the LIBERTY Peer Review Committee within a period not to exceed sixty (60) days, except in cases in which there is imminent harm to patient health, an action by a state dental licensing board or other governmental agency against the Dental Office's license to practice dentistry, or in cases of fraud. The Peer Review Committee shall include at least one representative in the Dental Office's same or similar specialty and be comprised of a provider who serves on the standing Quality Management and Improvement Committee. The decision of the Peer Review Committee, which must be rendered within sixty (60) days of Dental Office's request for review, will be made available to the Dental Office and will be considered but will not be binding on LIBERTY. Upon request, Dental Office shall be entitled to an expedited review process by LIBERTY. Except in cases of imminent harm to a Member, LIBERTY may not notify Members of the termination until the effective date of the termination or at such time that the Peer Review Committee makes a formal recommendation. Reasonable advance notice shall be given of the impending termination to Members who are at that time being treated by Dental Office.

6.3 **Effect of Termination:**

6.3.1 Notwithstanding any other provision in this contract, any termination of this Agreement shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination and any continuing obligations after termination as set forth herein.

6.3.2 In the event of the termination of this Agreement, Dental Office shall complete work started prior to the effective date of termination as follows:

6.3.2.1 If an impression has been taken, Dental Office will complete a partial or denture.

6.3.2.2 On every tooth upon which work has been started.

6.3.2.3 If a Member is undergoing Orthodontia treatment at the time of termination, Dental Office will complete this work at the agreed-upon discount in the schedule of benefits.

6.3.2.4 If, at the time the Dental Office receives notice of termination, the Dental Office is treating a Member with Special Circumstances, then for Continuity of Care, LIBERTY shall reimburse the Dental Office at no less than the contract rate for that Member's dental care in exchange for continued treatment by that Dental Office, unless the Dental Office has been terminated due to a lack of dental competence or professional behavior. LIBERTY shall reimburse a terminated Dental Office for ongoing treatment of Members with Special Circumstances for up to ninety (90) days after the effective date of termination, or for up to nine (9) months in the case of a Member who has been diagnosed with a terminal illness at the time of termination. The treating Dental Office is responsible for identifying a Member with Special Circumstances. The Dental Office must then request that the Member be permitted to continue treatment under the Dental Office's care and the Dental Office must agree not to seek payment from the Member of any amount for which the Member would not be responsible if the Dental Office continued to be included in LIBERTY's network. The Dental Office is responsible for submitting disputes regarding the necessity of continued treatment to the LIBERTY advisory review panel.

6.3.3 In the event of termination of this Agreement, Dental Office agrees to, at no cost to Member or LIBERTY, forward to the Member's newly-assigned Dental Office, at the request of the Member or newly-assigned Dental Office, copies of all patient records and copies of x-rays, within thirty (30) days after such request. Dental Office further agrees to return all LIBERTY materials to LIBERTY, including the Quality Assurance and Procedures Manual, upon LIBERTY's request.

6.3.4 LIBERTY/Payor will notify members regarding provider termination prior to the effective date. Dental Office agrees to charge the Member no more for his services than would have been payable by the Member had this Agreement not terminated.

ARTICLE VII - GENERAL PROVISIONS

7.1 **Waiver**: The waiver by either Party to this Agreement of any breach of any provision hereof on the part of the other shall not be construed to operate as a waiver of any other or subsequent breach of the same or any other term, condition or covenant contained in this Agreement.

7.2 **Entire Agreement**: This Agreement represents the entire understanding between the parties and supersedes any prior agreements or understandings with respect to the subject matter hereof. All amendments or modifications hereto shall be mutually agreed to in writing by LIBERTY and Dental Office, except as specified in Sections 7.13-7.14.

7.3 **Invalidity**: The invalidity or unenforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision.

7.4 **Assignment**: This Agreement shall not be assigned in whole or in part without the written consent of LIBERTY.

7.5 **Terms:** For simplicity of expression, pronouns and other terms are sometimes expressed in one number and gender, but where appropriate to the context these terms shall be deemed to include each of the other numbers and genders.

7.6 **Governing Law and Venue**: This Agreement shall be construed and enforced in accordance with the laws of the State of Texas and shall have as its exclusive venue the State of Texas, County of Travis and City of Austin for legal proceedings of any kind that may arise by reason of this Agreement.

7.7 **Financial Records**: Dental Office and LIBERTY shall cooperate in keeping financial and statistical records which may be necessary for the proper administration of LIBERTY or as required by state or federal laws and regulations. Such records shall be retained for a period of five (5) years. Such obligations shall not terminate upon termination of this Agreement whether by rescission or otherwise.

7.8 **Surcharges:** Dental Office is not permitted to surcharge any Member for covered services and shall, whenever a surcharge has erroneously occurred, upon notice by that Member or LIBERTY, refund such charge within five (5) days.

7.9 **Patient Records**: Dental Office shall maintain up-to-date records in accordance with accepted professional standards, sound dental accounting procedures and sound internal practices. Said records shall reflect the date each Member was seen, the procedures followed and the name, address and specialty of each specialist or other Dental Office to whom Member was referred. Such records shall be made available for inspection by LIBERTY during regular business hours and other reasonable times. LIBERTY shall from time to time provide forms for keeping certain records, which shall be submitted to LIBERTY as requested by LIBERTY.

7.10 **Retaliation**: LIBERTY shall not retaliate against the Dental Office because the Dental Office has reasonably filed a complaint, on a Member's behalf, against LIBERTY. Retaliation includes cancellation of or refusal to renew a contract. LIBERTY may not engage in retaliatory action, including refusal to renew or cancellation of coverage, against a group contract holder or Member because the group or Member or a person acting on behalf of the group or Member has filed a complaint against LIBERTY or appealed a decision of LIBERTY. LIBERTY may not engage in retaliatory action, including refusal to renew or termination of a contract, against a provider because the provider or complaint against LIBERTY or appealed decision of LIBERTY.

7.11 **Communications**: Any written mass communication relating to LIBERTY or its Dental Plan(s) (whether or not LIBERTY is specifically named) directed to Members by Dental Office must be reviewed and approved by LIBERTY prior to mailing. If Dental Office fails to submit such communication to LIBERTY for prior approval, LIBERTY may terminate this Agreement immediately.

7.12 **Provider Communications**: LIBERTY shall not prohibit, attempt to prohibit, or discourage Dental Office from discussing with or communicating to a current, prospective, or former Member, or a party designated by Member with respect to (1) information or opinions regarding Member's dental care, including the Member's medical or dental condition or treatment options, (2) information regarding the provisions, terms, requirements, or services of the dental plan as they relate to the dental needs of the Member, (3) the fact that Dental Office's contract with LIBERTY has terminated or that Dental Office will no longer be providing dental services under LIBERTY's dental plans, or (4) the fact that, if medically necessary covered services are not available through network Dental Offices, LIBERTY must, upon request of a network Dental Office and, within time appropriate to the circumstances relating to the delivery of the services and condition of the patient, but in no event to exceed five (5) business days after the receipt of reasonable requested documentation, allow referral to a non-network Dental Office.

7.13 **Additional Plans**: LIBERTY may, from time to time, amend, delete or add to its various Dental Plans. In such an event, LIBERTY shall send Dental Office these changes to reflect those amendments, deletions or additions at the address in Section 9.1.B If Dental Office does not accept such changes, Dental Office shall notify LIBERTY in writing by registered or certified mail at the address in Section 9.1.A within 10 days of receipt of such notification from LIBERTY and in such event, those Exhibits shall not become part of this Agreement. If Dental Office does not accept such changes then LIBERTY has the right to terminate this Agreement, subject to ninety (90) days prior notice. If Dental Office does not so notify LIBERTY, then those changes shall become part of this Agreement.

7.14 **Provider Reference Guide**: The LIBERTY Provider Reference Guide and any updates to the Guide will be provided to the dental office by paper, CD/ROM, or Web Site.

ARTICLE VIII - MEDIATION and BINDING ARBITRATION

8.1 **Dispute Resolution Process**: It is the agreement of the Parties to encourage the amicable resolution of any disputes arising under this Agreement including the use of voluntary settlement procedures.

8.2 **Mediation**: In the event of any dispute, claim or controversy between the parties arising out of or relating to this Agreement, or any of the documents executed pursuant to this Agreement, whether in contract, tort or otherwise, and whether relating to the meaning, interpretation, effect, validity, performance or enforcement of this Agreement, the parties agree to submit such controversy to mediation before a mediator duly qualified in accordance with the applicable Texas Statutes then in effect; provided, however, that this agreement to mediate shall not preclude the parties from pursuing equitable relief in a court of competent jurisdiction in Travis County, Texas. In the event the parties cannot agree on a mediator, each Party shall submit the name of two mediators, so qualified, and the four names shall be submitted to a sitting State District Court Judge in Travis County, Texas. Said judge may select from the list of four submitted names or may select a mediator not listed. Following selection of the mediator, the controversy shall be mediated by the parties within thirty (30) days.

8.3 Any dispute that cannot be resolved by Mediation will be submitted to binding arbitration under the commercial rules of the AMERICAN ARBITRATION ASSOCIATION and the determination of the Arbitration may be entered in any court of competent jurisdiction.

ARTICLE IX - NOTICES

9.1 All notices required to be given hereunder shall be in writing, and all such notices and documents to be delivered hereunder shall be either delivered in person to any signatory hereof or mailed by certified mail, return receipt requested. Until notice of a change of address is given, all such notices and documents shall be given or addressed:

A. To LIBERTY, addressed as follows:

LIBERTY Dental, P.A.
340 Commerce, Suite 100
Irvine CA 92602

B. To Dental Office, it shall be addressed as indicated on signature page.

THIS AGREEMENT is executed in several counterparts. Each is hereby declared to be an original; however, all shall constitute but one and the same Agreement.

IN WITNESS WHEREOF the parties have duly executed this Agreement as of the Effective Date:.

("DENTAL OFFICE"):

Authorized Signature

Print Name of Signatory

Title

Date

Dental Office Name

Dental Office Address

City, State ZIP

Primary Dentist License #

SS# and/or Tax ID#

Individual National Provider Identifier (NPI)

Organizational National Provider Identifier (NPI)
(if applicable)

LIBERTY DENTAL, P.A. ("LIBERTY"):

Signature

Print Name of Signatory

Title

Effective Date

Texas Medicaid Addendum

The following provisions are required by the Texas Medicaid and/or CHIP programs. The Agreement shall be automatically modified to conform to subsequent amendments to such program requirements. Any purported modification to the Agreement inconsistent with such program requirements is not effective.

1) ***Liability***. In the event Health Plan becomes insolvent or ceases operations, Provider understands and agrees that its sole recourse against Health Plan will be through the Health Plan's bankruptcy, conservatorship, or receivership estate. (UMCC Att. A, §4.05(f).)

Provider understands and agrees that HHSC does not assume liability for the actions of, or judgments rendered against, Health Plan, its employees, agents or subcontractors. Further, Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to Provider by the Health Plan or any judgment rendered against the Health Plan. HHSC's liability to Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 et seq.). (UMCC Att. A, §4.05(f).)

2) ***Marketing***. Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in the UMCC (which includes UMCM). (UMCC Att. B-1, §8.1.6, UMCM, Ch. 4.)

Provider is prohibited from engaging in direct marketing to enrollees that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance. (UMCC Att. B-1, §8.1.6, UMCM Ch. 4)

3) ***Medicaid Provider Agreement***. Acute care providers serving Medicaid Members must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in the Medicaid Program, and must have a Texas Provider Identification Number (TPIN). All Providers, both CHIP and Medicaid, must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D (for most Providers, the NPI must be in place by May 23, 2007.) (UMCC Att. B-1, §8.1.4.)

4) ***Member Communications***. Health Plan is prohibited from imposing restrictions upon Provider's fee communication with a Member about the Member's medical conditions, treatment options, Health Plan referral policies, and other Health Plan policies, including financial incentives or arrangements and all managed care plans with whom Provider contracts. (UMCC Att. A, §7.02, and BAA §438.102.)

5) ***Primary Care Physicians (PCPs)***. To the extent Provider is a primary care physician:

a. Provider shall be accessible to members 24 hours per day, 7 days per week. (UMCC Att. B01, §8.1.4.)
b. Provider shall provide preventative care (i) to children under age 21 in accordance with AAP recommendations for CHIP Members and the THSteps periodicity schedule published in the THSteps Manual for Medicaid Members; and (ii) to adults in accordance with the U.S. Preventative Task Force requirements. (UMCC Att. B-1, §8.1.4.2.)

6) **Access to Records**

The Network Provider agrees to provide the Texas Health and Human Services Commission (HHSC):

1. all information required under the Network Provider contract, including but not limited to the reporting requirements and other information related to the Network Provider's performance of its obligations under the contract; and
2. any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations.

All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by HHSC. (HHSC Att. E)

7) **Advance Directives**

Provider must comply with the requirements of state and federal laws, rules and regulations relating to advance directives. (HHSC Att. E)

8) **Audit or Investigation**

The Network Provider agrees to provide the following entities or their designees with prompt, reasonable, and adequate access to the Network Provider contract and any records, books, documents, and papers that are related to the Network Provider contract and/or the Network Provider's performance of its responsibilities under this contract:

1. HHSC and MCO Program personnel from HHSC;
2. U.S. Department of Health and Human Services;
3. Office of Inspector General and/or the Texas Medicaid Fraud Control Unit;

4. an independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;
5. state or federal law enforcement agency;
6. special or general investigation committee of the Texas Legislature; and
7. any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

The Network Provider must provide access wherever it maintains such records, books, documents and papers. The Network Provider must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein. (HHSC Att. E)

9) **Claims Payment**

MCO will provide the Network Provider at least 90 days notice prior to implementing a change in the above-reference claims guidelines. Unless the change is required by statute or regulation in a shorter timeframe.

The MCO must notify Network Providers in writing of any changes in the list of claims processing or adjudication entities at least 30 days prior to the effective date of change. If MCO is unable to provide 30 days notice, the MCO must give Network Providers a 30-day extension on their claims filing deadline to ensure claims are routed to correct processing center.

The MCO shall adjudicate (finalize as paid or denied adjudicated) clean claims within 30 days from the date the claim is received by the MCO. The MCO will pay Network Providers interest at a rate of 1.5% per month (18% per annum) on all clean claims that are not adjudicated within 30 days. (HHSC Att. E)

10) **Complaints**

The Network Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and conduct investigations into Provider and Member complaints. (HHSC Att. E)

11) **Confidentiality**

Network Provider must treat all information that is obtained through the performance of the services included in this Network Provider contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC Programs.

Network Provider shall not use information obtained through the performance of this Network Provider contract in any manner except as is necessary for the proper discharge of obligations and securing of rights under this contract. (HHSC Att. E)

12) **Confidentiality – HIPAA**

Network Provider shall not transfer and identifiable Member record, including a patient record, to another entity or person without written consent from the Member or someone authorized to act on his or her behalf; however, Network Provider understands and agrees that HHSC may ask it to transfer a Member record to another agency if HHSC determines that the transfer is necessary to protect either the confidentiality of the record or the health and welfare of the Member. (HHSC Att. E)

13) **Costs of Non-covered Services**

The Network Providers must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed Private Pay form from such a Member. (HHSC Att. E)

14) **Fraud and Abuse**

The Network Provider understands and agrees to the following:

1. HHSC Office of Inspector General ("OIG") and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Network Providers and their employees, agents, contractors, and patients;
2. requests for information from such entities must be complied with, in the form and language requested;
3. Network Providers and their employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at the Network Provider's own expense; and
4. compliance with these requirements will be at the Network Provider's own expense. (HHSC Att. E)

The Network Provider understands and agrees to the following:

1. Network Providers are subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care and the Medicaid and/or CHIP Programs, as applicable;
2. Network Providers must cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste;
3. Network Providers must provide originals and/or copies of any and all information, allow access to premises and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge;
4. if the Network Provider places required records in another legal entity's records, such as a hospital, the Network Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
5. Network Providers must report any suspected fraud or abuse including any suspected fraud and abuse committed by MCO or a Member to the HHSC Office of Inspector General. (HHSC Att. E)

15) **Laws, Rules, and Regulations**

The Network Provider understands and agrees that it is subject to all state and federal laws, rules, regulations and waivers that apply to the Network Provider Contract, the HMO Program, and all persons or entities receiving state and federal funds. The Network Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Network Provider contract, or any violation of the Texas Health and Human services Commission/MCO contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law. (HHSC Att. E)

("DENTAL OFFICE")	**LIBERTY DENTAL, P.A. ("LIBERTY"):**
Authorized Signature	Signature
Print Name	Print Name
Title	Title
Date	Date
Individual TPI#	
Group TPI#	

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally 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.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

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); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 3.

Sign Here	**Signature of U.S. person** ▶	**Date** ▶

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

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, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Texas Provider Credentialing Application

It is required that you include the following documentation with your contracting documents to become a LIBERTY Dental Plan provider. Individual Provider Credentialing Applications are necessary for the Practice Owner and for each Associate Dentist rendering services.

The State of **Texas** has mandated the use of their State Credentialing Application. It is only necessary to complete the following pages for LIBERTY'S credentialing process:

- **Pages 1 – 4** (Filled in completely – Page 3 requires 5 years of Work History or back to graduation date – CV's not accepted unless current)
- **Page 5 – 6** (Check yes or no)
- **Pages 7 – 8** (Sign and date)
- **Attachments A and B**
- **Attachment G** (As applicable to your Attestation – must sign and date)

Include current copies of the following:

- **Dental License**
- **DEA or DPS License**
- **Malpractice Insurance** (Declaration Page)
- **Specialty Certificate** (if applicable)

Pursuant to Texas Insurance Code § 1452.052, LHL234 Rev. 01/07 is promulgated by the Texas Department of Insurance. Please send this application to the carrier with whom you wish to become credentialed.

Texas Standardized Credentialing Application

(Please type or print)

Section I-Individual Information

TYPE OF PROFESSIONAL
DENTAL

LAST NAME	FIRST	MIDDLE	(JR., SR., ETC.)

MAIDEN NAME	YEARS ASSOCIATED (YYYY-YYYY)	OTHER NAME	YEARS ASSOCIATED (YYYY-YYYY)

HOME MAILING ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

HOME PHONE NUMBER	SOCIAL SECURITY NUMBER	☐ Female ☐ Male

CORRESPONDENCE ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

DATE OF BIRTH (MM/DD/YYYY)	PLACE OF BIRTH	CITIZENSHIP

IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS	ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? ☐ Yes ☐ No

U.S.MILITARY SERVICE/PUBLIC HEALTH ☐Yes ☐ No	DATES OF SERVICE (MM/DD/YYYY) TO (MM/DD/YYYY)	LAST LOCATION

BRANCH OF SERVICE	ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY? ☐ Yes ☐ No

Education

PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.)
Issuing Institution:

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)

☐ *Please check this box and complete and submit Attachment A if you received other professional degrees.*

POST-GRADUATE EDUCATION SPECIALTY
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)

POST-GRADUATE EDUCATION SPECIALTY
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

Education - *continued*

POST-GRADUATE EDUCATION ☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)

☐ Please *check this box and complete and submit Attachment B if you received additional postgraduate training.*

OTHER GRADUATE-LEVEL EDUCATION Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	

Licenses and Certificates - Please include all license(s) and certifications in all States where you are currently or have previously been licensed.

LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
☐ DEA Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
☐ DPS Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
OTHER CDS (PLEASE SPECIFY)	NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No

UPIN	NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE)
ARE YOU A PARTICIPATING MEDICARE PROVIDER? ☐ Yes ☐ No Medicare Provider Number:	ARE YOU A PARTICIPATING MEDICAID PROVIDER? ☐ Yes ☐ No Medicaid Provider Number:
EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) ☐ N/A ☐ Yes ☐ No ECFMG Number:	ECFMG ISSUE DATE (MM/DD/YYYY)

Professional/Specialty Information

PRIMARY SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

SECONDARY SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

Professional / Specialty Information *-continued*

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

ADDITIONAL SPECIALTY	BOARD CERTIFIED? ☐Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.)

Work History

- Please provide a chronological work history. You may submit a Curriculum Vitae as a supplement. Please explain all gaps in employment that lasted more than six months.

CURRENT PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE

PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/YYYY TO MM/YYYY) IN WORK HISTORY.

Gap Dates: Explanation:

Gap Dates: Explanation:

Hospital Affiliations-*Please include all hospitals where you currently have or have previously had privileges.*

DO YOU HAVE HOSPITAL PRIVILEGES? ☐ Yes ☐ No	IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE?	
PRIMARY HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No

Professional Liability Insurance Coverage

SELF-INSURED? ☐ Yes ☐ No	NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY		
ADDRESS			
CITY	STATE/COUNTRY		POSTAL CODE
PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE ☐ Individual ☐ Shared	LENGTH OF TIME WITH CARRIER
NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS			
ADDRESS			
CITY	STATE/COUNTRY		POSTAL CODE
PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE ☐ Individual ☐ Shared	LENGTH OF TIME WITH CARRIER

Practice Location Information – *Please answer the following questions for each practice location.* PRACTICE LOCATION of

TYPE OF SERVICE PROVIDED
☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ☐ Group Multi-Specialty

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9	
PRACTICE LOCATION ADDRESS ☐ **Primary**		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL
BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER
GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER	
ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ☐ Yes ☐ No	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ☐ Yes ☐ No
OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER
CREDENTIALING CONTACT		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL

Section II-Disclosure Questions - Please *provide* an explanation for any question answered yes-except 16-on page 10.

Licensure

1 Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?

☐ Yes ☐ No

2 Have you ever received a reprimand or been fined by any state licensing board?

☐ Yes ☐ No

Hospital Privileges and Other Affiliations

3 Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?

☐ Yes ☐ No

4 Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?

☐ Yes ☐ No

5 Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?

☐ Yes ☐ No

Education, Training and Board Certification

6 Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?

☐ Yes ☐ No

7 Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?

☐ Yes ☐ No

8 Have any of your board certifications or eligibility ever been revoked?

☐ Yes ☐ No

9 Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?

☐ Yes ☐ No

DEA or DPS

10 Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?

☐ Yes ☐ No

Medicare, Medicaid or other Governmental Program Participation

11 Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?

☐ Yes ☐ No

Other Sanctions or Investigations

12 Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?

☐ Yes ☐ No

Section II - Disclosure Questions - *continued*

Other Sanctions or Investigations

13 To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?

☐ Yes ☐ No

14 Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

☐ Yes ☐ No

15 Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?

☐ Yes ☐ No

Malpractice Claims History

16 Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated?

☐ Yes ☐ No

☐ *If yes, please check this box and complete and submit Attachment G.*

Criminal

17 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional

☐ Yes ☐ No

18 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?

☐ Yes ☐ No

19 Have you been court-martialed for actions related to your duties as a medical professional?

☐ Yes ☐ No

Ability to Perform Job

20 Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

☐ Yes ☐ No

21 Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

☐ Yes ☐ No

Ability to Perform Job

22 Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?

☐ Yes ☐ No

23 Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?

☐ Yes ☐ No

Please use the space on page 10 to explain yes answers to any question except #16.

Section III – Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with

(PLEASE INDICATE MANAGED CARE COMPANY(S) OR HOSPITAL(S) TO WHICH YOU ARE APPLYING) (HEREINAFTER, INDIVIDUALLY REFERRED TO AS THE "ENTITY")

LIBERTY DENTAL PLAN

and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

For Hospital Credentialing. I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (I) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third

_____

APPLICANT'S INITIALS AND DATE (MM/DD/YYYY)

Section III – Standard Authorization, Attestation and Release – continued

party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

SIGNATURE

NAME (PLEASE PRINT OR TYPE)

Last 4 digits of SSN or NPI (PLEASE PRINT OR TYPE)

DATE (MM/DD/YYYY)

Required Attachments or Supplemental Information – Please attach hard copy or scanned documents of the following:

- ☐ Copy of DEA or state DPS Controlled Substances Registration Certificate
- ☐ Copy of other Controlled Dangerous Substances Registration Certificate(s)
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant's name
- ☐ Copies of IRS W-9s for verification of each tax identification number used
- ☐ Copy of workers compensation certificate of coverage, if applicable
- ☐ Copy of CLIA certifications, if applicable
- ☐ Copies of radiology certifications, if applicable
- ☐ Copy of DD214, record of military service, if applicable

Notice About Certain Information Laws and Practices Pertaining to State Governmental Bodies (i.e. State Hospitals)

With few exceptions, you are entitled to be informed about the information that a state governmental body collects about you (i.e. a state hospital). Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However the state governmental body may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that the state governmental body correct information that it has about you that is incorrect. For information about the procedure and costs for obtaining information, please contact the appropriate state governmental body to which you have submitted this application.

OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
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ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	

OTHER POST-GRADUATE EDUCATION ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment	SPECIALTY	
INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)	
OTHER POST-GRADUATE EDUCATION ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment	SPECIALTY	
INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	
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INSTITUTION		
ADDRESS		
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OTHER POST-GRADUATE EDUCATION ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment	SPECIALTY	
INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
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PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)	
OTHER POST-GRADUATE EDUCATION ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment	SPECIALTY	
INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)	

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID $ $
METHOD OF RESOLUTION ☐ Dismissed	☐ Settled (with prejudice)	☐ Settled (without prejudice)
☐ Judgment for Defendant(s)	☐ Judgment for Plaintiff(s)	☐ Mediation or Arbitration
DESCRIPTION OF ALLEGATIONS		
WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT		
TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)? ☐ Yes ☐ No		

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID $ $
METHOD OF RESOLUTION ☐ Dismissed	☐ Settled (with prejudice)	☐ Settled (without prejudice)
☐ Judgment for Defendant(s)	☐ Judgment for Plaintiff(s)	☐ Mediation or Arbitration
DESCRIPTION OF ALLEGATIONS		
WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT		
TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)? ☐ Yes ☐ No		

Electronic Fund Transfer (EFT) Form

(Please Print Clearly)

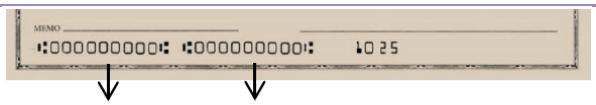
FACILITY INFORMATION

Type of Authorization: ☐ Add ☐ Update ☐ Cancel

Facility Name:	Facility ID:	Tax ID:
Facility Address:		
Email Address:		
UPDATED EMAIL ADDRESS:		

ACCOUNT INFORMATION

Account Legal Name:	Account Number:
Account Type: ☐ Checking ☐ Savings	Bank Routing Number:
Name of Financial Institution:	



Routing Number Account Number

One of the following must be attached:

☐ Voided Check

☐ Confirmation letter from your bank with required account information

AUTHORIZATION

Please note that all references to "me," "my" or "I" below refer to the dental office contracted with LIBERTY Dental Plan and to which payments shall be directly deposited by LIBERTY Dental Plan under this authorization form.

By signing below, I hereby authorize LIBERTY Dental Plan to deposit any amounts due to me, less any mandatory or authorized withholdings or deductions, into the account indicated on this form. I understand that my payment statements will be available online and that paper statements will no longer be provided to me.

If at any time the amount so deposited exceeds the amount actually due and payable to me, I hereby authorize LIBERTY Dental Plan to either: (i) withhold a sum equal to the overpayment from future amounts due to me; or (ii) recover such overpayment from the above-indicated account. I understand that it is my responsibility to verify that payments have been credited to my account and I agree that LIBERTY Dental Plan assumes no liability for overdrafts for any reason whatsoever. I further understand that in the event my financial institution is not able to deposit any electronic transfer into my account due to any action or inaction by me, LIBERTY Dental Plan cannot issue the funds to me until the funds are returned to LIBERTY Dental Plan by the financial institution.

I certify that the account is drawn in my name and that I have sole control of the account. I certify that the account is drawn in the legal business name of the dental office and that such dental office has sole control of the account. Either way, I certify that all arrangements between my financial institution(s) and me are in accordance with all applicable federal and state laws and regulations.

This authorization will remain in effect until I have submitted a new Electronic Fund Transfer Form to LIBERTY Dental Plan or until either Dental Plan or I have provided the other with written notice to terminate this authorization or direct deposit arrangement. I understand that I can change my account information or financial institution arrangement by completing a new Electronic Fund Transfer Form available from LIBERTY Dental Plan. I agree to immediately notify LIBERTY Dental Plan before I close any account listed above while this authorization is in effect.

By signing below, I certify that 100% of the net deposit will not be sent to a financial institution outside the jurisdiction of the United States.

Authorized Signature:	Date:
Print Name:	Title:

CANCELLATION

I hereby cancel my Electronic Fund Transfer Authorization.	
Authorized Signature:	Date:
Print Name:	Title:

LIBERTY DENTAL PLAN USE ONLY

Vendor Name:	Vendor ID:

Electronic Fund Transfer (EFT) Form

(Please Print Clearly)

Instructions for Completing the Electronic Fund Transfer (EFT) Form

Please allow 30 days after submission of form to receive your first Electronic Fund Transfer (EFT) deposit. Forms that are illegible or not fully or accurately completed will result in delays in processing the EFT deposit arrangement.

General Instructions
Complete all portions of the form according to the type of enrollment and sign where required.

Facility Information – Clearly print and complete all parts of this section for any addition, update or cancellation to account. Enter your current email address for verification purposes in the "Email Address" section.

Update to Email Address – Clearly print the email address you wish to update the account to in the "Updated Email Address" section. (A **voided check or bank letter will not be required** for submission if this is the only change to the account information.)

Account Information - Attach a voided check or Confirmation Letter from your bank for the account listed. Please note that this EFT Form will not be processed unless the voided check or bank letter is attached.

Authorization – An authorized signature is required for any addition, change or update to an account. The signer's name must be clearly printed under the signature, title provided, and form dated. Omission will result in delays in processing this EFT form.

Cancellation - An authorized signature is required for cancellation of the EFT deposit arrangement. The signer's name must be clearly printed under the signature, title provided, and form dated. Omissions will result in delays in processing of the EFT form.

Please return the completed EFT form along with all required documents by email or regular mail.

Email submissions to: **prinquiries@libertydentalplan.com**

Mail submissions to:

Attn. Professional Relations
LIBERTY Dental Plan
P.O. Box 26110
Santa Ana, CA 92799

LIBERTY Provider Compliance Attestation

I certify that I am an authorized representative of the Provider named below, for all locations listed below, and confirm the following representations are true, based upon current information and reasonable belief:

1. **CMS Compliance & FWA Training.** Provider complies with all Centers for Medicare and Medicaid Services (CMS) General Compliance and Fraud Waste and Abuse (FWA) training requirements, including ensuring that all Provider employees and other personnel who support LIBERTY business, including LIBERTY's Plan Partners' Medicare Advantage, Medicare-Medicaid (Duals), and/or Medicaid business ("LIBERTY Government Business") receive both General Compliance and FWA training within 90 days of hire, and annually thereafter, utilizing one or more of the following methods:

    - General Compliance and FWA training is completed using the web-based modules located on the CMS Medicare Learning Network (MLN) at:

        https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf

        https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf

    and/or

    - Provider distributes LIBERTY's FWA Training (available at www.libertydentalplan.com) to all Provider employees and other personnel who support LIBERTY Government Business, within 90 days of hire and annually thereafter.

2. **Code of Conduct.** Provider distributes a Code of Conduct (LIBERTY's or Provider's own Code of Conduct, if comparable to LIBERTY's)* to all Provider employees and other personnel who support LIBERTY Government Business, within 90 days of hire and annually thereafter.

    - Provider distributes LIBERTY's Code of Conduct located at www.libertydentalplan.com

    and/or

    - Provider distributes its own Code of Conduct, which is comparable to LIBERTY's.

3. **Cultural Competency & Critical Incident Training.** Provider ensures all Provider employees and other personnel who support LIBERTY's Government Business complete LIBERTY's Cultural Competency & Critical Incident trainings within 90 days of hire and annually thereafter. To access the training, visit www.libertydentalplan.com and select Providers.

4. **Record Retention.** Provider maintains supporting documentation for a period of ten (10) years after training completion, and Code of Conduct dissemination, for all Provider employees and other personnel supporting LIBERTY Government Business, and can furnish the documentation upon request.

**Note: LIBERTY is required to communicate, through dissemination of LIBERTY's Code of Conduct, its commitment to conducting business in an ethical manner, and consistent with governing law and program requirements. LIBERTY will also accept the dissemination of Provider's comparable Code of Conduct to fulfill this requirement.*

LIBERTY Provider Compliance Attestation

*Office Locations:

Office ID	Office Name	Address

**For multiple locations, please attach a list of all applicable Dental Office Names and Addresses.*

Provider Name (Owner Dentist)

To be completed by Provider (or authorized representative):

Print Name

Title

Signature

Date

LIBERTY Dental Plan

PROVIDER AUTHORIZED SIGNATORY FORM

"Dental Office": _____
Dental Office Name

_____
Dental Office Address - if these signatories are authorized for multiple locations, please attach a list of all applicable Dental Office Names and Addresses

By signing this Provider Authorized Signatory Form, Dental Office represents and warrants that the individuals listed below are Authorized Signatories, as defined herein. "Authorized Signatories" are those individuals who are authorized by Dental Office to approve, sign and execute, acknowledge, and deliver, in the name and on behalf of Dental Office, any and all contracts, including but not limited to: provider agreements, addenda, fee schedules, amendments, letters of intent, letters of agreement, memoranda of understanding, applications, attestations, settlements, releases, waivers, renewals, and all other forms, documents, and agreements (collectively, "Contracts"). Dental Office represents and warrants that all Authorized Signatories are authorized to bind Dental Office to all such Contracts.

AUTHORIZED SIGNATORIES	
Name	**Title**

Dental Office acknowledges and agrees that LIBERTY Dental Plan ("LIBERTY") is not required to accept all Authorized Signatories and further acknowledges and agrees that some Contracts (such as credentialing applications, DEA Waiver Request forms, etc.) may require a dentist or other specific signature. In the event of any changes to its Authorized Signatories, Dental Office shall immediately notify LIBERTY of such changes in writing and shall complete a new Provider Authorized Signatory Form.

LIBERTY Dental Plan
Attention: Professional Relations
340 Commerce, Suite 100
Irvine, CA 92602
prnational@libertydentalplan.com

Acknowledged and agreed:

Note: If the dental practice is not incorporated, the dentist/owner must sign.
If the dental practice is incorporated, the President, CEO, or Chairman must sign.

_____
Authorized Signature

_____
Print Name

_____
Title

_____
Date