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QUICK REFERENCE GUIDE

Professional Relations - (800) 307-8514
United Concordia Companies, Inc.
Attn: Professional Relations
PO Box 69409
Harrisburg, PA 17106-9409

My Professional Relations Representative is:

Extension: _______________________

Customer Service - (866) 357-3304
Contact Customer Service for all questions regarding benefits, eligibility, claim status, claim payments, members initiated transfer request, etc.

United Concordia Companies, Inc.
Attn: Claims Appeal
PO Box 69420
Harrisburg, PA 17106-9420

Interactive Voice Response (IVR) - (866) 357-3304
Provides enrollment, procedure history, claim status, and benefit information, 24 hours a day, 7 days a week.

Claims Processing
United Concordia Companies, Inc.
Attn: Claims Processing
PO Box 69422
Harrisburg, PA 17106-9422

Request Open/Closed Status
Submit your request in writing to Provider Data Management at fax (866) 223-2770

Dental Electronic Services - (800) 633-5430
United Concordia Companies, Inc.
Attn: Dental Electronic Services
PO Box 69408
Harrisburg, PA 17106-9408

Refer to the Automated Services section of this guide for more information.

My United Concordia Web site User Login ID is:

My password is:

HIPAA
For more information, visit the following Web sites:

For implementation guides or the x12N transaction standards at no cost:
http://www.wpc-edi.com/hipaa

Privacy Information from the Office of Civil Rights:
http://www.hhs.gov/ocr/hipaa
INTRODUCTION TO UNITED CONCORDIA

Valuing Your Participation

Our networks help provide members in all 50 states, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands with convenient access to care and hassle-free administration. We value your participation in our Concordia PLUS network. Our experienced staff works hard to make your interactions with us as simple and seamless as possible. And, we continually seek new and innovative offerings to better serve you.

We look forward to providing quality service and support to you and your office for many years to come.

About United Concordia

United Concordia is one of the nation’s largest and most respected dental insurance companies. Established in 1992 as a wholly-owned subsidiary of Highmark, Inc. (a Pennsylvania non-profit health service plan), United Concordia is exclusively focused on providing high-quality, cost-effective dental benefits programs to clients ranging from small, local businesses to large, global organizations.

Our diverse product portfolio includes fee-for-service, dental health maintenance organizations (DHMOs) and preferred provider organizations (PPOs). To support these products, United Concordia maintains some of the largest dentist networks in the nation, which provide access to more than 68,000 dentists at 111,000 practice locations. We also offer a full-array of innovative electronic tools and world-class customer service.

United Concordia’s exclusive focus allows us to:

• Serve more than 8 million members worldwide

- Process over 13 million claims and handle more than 10 million telephone and written inquiries annually
- Offer privacy protection with a U.S. Department of Defense security designation
- Employ more than 1,280 people at our corporate headquarters and 27 offices nationwide

Our Product Options

United Concordia’s flexible product lines include:

• Dental Health Maintenance Organizations (DHMO)
• Preferred Provider Programs (PPO)

Note: A separate Participating Provider Agreement is required for each product line.

About the Dental Reference Guide

This Dental Reference Guide is designed to provide you and your office staff with information about our DHMO plans. While it is not intended to be the sole legal basis for contract/benefit interpretation, it should serve as your reference guide for eligibility, coverage, policies, procedures, procedure codes, claims and payments.

Familiarity with the concepts in this reference guide and United Concordia procedures and policies will ensure proper and efficient administration. If you find anything in this reference guide which you feel is unclear, please contact your Professional Relations Representative.
ADMINISTRATION

Enrollment/Site Selection
At the time of enrollment, each employee of a group is given an application to complete. Included on the application is a section to select a dental office. Each employee and their dependents (spouse/children) are instructed to select a provider/office of their choice. There is no requirement stating that each person in a family must select the same office, but generally the whole family chooses the same dental office for their care.

If an employee does not select a dental provider/office, they are automatically assigned to an office by matching the member’s home zip code to that of a dental office in our network. By assigning all members, capitation is paid for every member/dependent enrolled.

Eligibility Verification
Please confirm eligibility prior to providing care on a monthly basis.

All United Concordia members are issued two identification cards. This card provides you with the information you need to verify the eligibility.

There are several ways to check a member’s eligibility:
• Provider Capitation Statement (roster)
• Online at www.unitedconcordia.com
• Interactive Voice Response (IVR) System at (866) 357-3304
  » If you have a touch tone phone, Press Option 1
  » Enter your provider number
  » Press Option 1 for eligibility
  » Enter Member ID Number

Note: If a member’s name does not appear on your Capitation Statement, call United Concordia Customer Service at (866) 357-3304 to confirm eligibility through our automated eligibility system, IVR.

If eligibility can not be established, the member can still be seen for his/her appointment. However, the member should be advised of his/her financial responsibility. The member should then sign a Waiver of Liability form.

If and/or when eligibility is established, any monies the member has paid beyond his/her copayment should be refunded.

Note: Do not call the member’s group/plan administrator to verify eligibility.

Eligible Dependents
• Legal spouse or domestic life partner as defined by contract holder and/or state law
• Any unmarried child including adopted children of member who is under the age of 19 (varies by plan)
• Any unmarried child between the ages of 19-26, who is a full time student enrolled in 12 or more units per semester (varies by plan)
• Any unmarried child of subscriber, regardless of age, if child is chiefly dependent upon subscriber for maintenance and support and is incapable of self sustaining employment because of mental handicap or developmental disability

Waiver of Liability
In an effort to protect the interests of our participating dental offices when member eligibility cannot be verified and to help ensure that members receive necessary care, we have created a Waiver of Liability Form for your use. An example of the form in English and Spanish is provided on the next page.

This form should be used whenever there is a question regarding eligibility. First, have the member complete the form. It must be signed by both the member and dentist or front office manager, and a copy should be retained for your records. Then, follow your normal payment collection procedures.

Upon confirmation of eligibility, your office should reimburse the member for any monies collected over and above the plan copayments.
Note: Your office will receive an adjustment on the Provider Capitation Statement for any members who are added to your office retroactively.

Example Waiver of Liability Forms

Waiver of Liability Form (English)

On this date I, _________________________________ (Name of Subscriber/Dependent), understand that United Concordia Companies, Inc. is unable to verify eligibility for me and/or my dependent(s) in the office of _______________________________ (name of participating dentist/dental group) on ____________ (date) through ______________________________ (name of union, trust, or employer). I also understand I am responsible to pay the full usual fee(s) for any services rendered on this date by the above dentist(s). Once United Concordia has received verification from my union, trust, or employer of my eligibility in this office on this date, the dental office will reimburse me for any monies collected over and above my plan copayments.

________________________________           __________________________________
Signature of Subscriber/Dependent              Signature of Dentist or Authorized Staff Member

________________________________
Subscriber’s Identification Number

One copy to patient
and one copy to dental office

Forma de Reembolso (Espanol)

En esta fecha Yo, _________________________________ (nombre del asegurado/paciente), tengo entendido que United Concordia Companies, Inc. no puede verificar elegibilidad para mi y/o mis dependientes en la oficina _______________________________ (nombre del dentista/oficina participante) el dia ____________ (fecha) a travez ______________________________ (nombre de la union/compania) tambien tengo entendido que yo soy responsable de pagar los precios regulares del dentista por cualquier servicio o tratamiento prestado ahora. Media vez United Concordia haya recibido verificacion de mi union o empleador acerca de la fecha de mi elegibilidad, la oficina dental sera responsable de devolverme todo el dinero pagado en exceso de mis copagos correspondientes.

_______________________________
Firma del Dentista o firma del

_______________________________
Seguro social de identificacion

One copy to patient
and one copy to dental office
Appointment of Members
As a participating dentist in United Concordia’s network, the dentist agrees to:

- Offer appointments to United Concordia members using standards applicable to his/her other patients.
- Accept patients into his/her practice and provide services to patients regardless of race, creed, color, sex, insurance coverage, health or national origin.
- Offer appointments to members with reasonable waiting periods (as determined by local standards of practice).

Patient Utilization Information
United Concordia is required by law to maintain utilization statistics on all members. In addition, we track utilization patterns for quality management and standards of care.

Please use black or dark blue ink when completing the claim form and indicate the following:

- Member ID
- Patient’s name
- Patient’s address
- Patient’s Date of Birth
- Patient’s Relationship to Subscriber
- Date of service
- Provider Number
- Provider TIN Number
- Provider Address
- Procedure Code
- Tooth number(s) & Surface number(s) treated and Tooth surface(s) involved

Closed Status Offices
Offices that are closed to new enrollment must treat all members appearing on their eligibility report at the time of closure. This includes any members who have not had initial treatment prior to the office being placed on closed status.

An office may request to be placed on closed status. Requests should include the reason for status change and should be faxed to Provider Data Management at (866) 223-2770.

The office will be placed on closed status upon receipt of the written request. Requests to reopen to new enrollment should be submitted to the same fax number and the office will be placed on active status upon receipt of the written request.

Claim (Utilization) Submission Requirements
After treatment is completed, submit one ADA claim form per patient for all procedures performed.

Mail completed ADA claim forms to:
United Concordia Companies, Inc.
Attn: Claims Processing
PO Box 69422
Harrisburg, PA  17106-9422

Capitation Cycles
The DHMO Eligibility/Capitation Reports are run on the first business day of each month. They are mailed or immediately available online in a printer friendly format. You can review your reports online for the most recent three months.

To access the reports online at www.unitedconcordia.com, click on For Dentists, then DHMO Reports. A user identification and password are required. If you are a current user of Speed eClaim® and/or My Patients’ Benefits, you are already registered under the same user identification and password.

If you have questions on the use of this feature, please contact Dental Electronic Services at (800) 633-5430. If you have questions regarding your check or eligibility report, please contact Customer Service at (866) 357-3304.

Provider Capitation Statement (Eligibility Listing)
This report provides a roster of all eligible members assigned to the Primary Dental Office. The report details Current Month
Capitation dollars and Retroactivity dollars calculated for each member. Additional data such as Member ID, Benefit Schedule Name, Group Number, Date of Birth, Member’s Sex and Member’s Relationship to the Applicant Subscriber is also supplied on this report. If a member is a new Add, Retroactive Termination, Retroactive Transfer In/Out, or Terminated, this information is provided in the Action Code (Act Cd) column on the report.

This report should be received in the dental office during the first week of each month. The roster is also available online at www.unitedconcordia.com.

The following information is itemized on the Eligibility Listing:

- **Name:** Last Name, First Name of the member
- **Member ID:** The member’s contract ID (Social Security Number or Unique Member Identifier)
- **Plan Number:** The member’s benefit schedule or plan type
- **Group Number:** The nine-digit number assigned to the group by United Concordia
- **Date of Birth:** The member’s date of birth
- **Sex:** The member’s sex
- **Rel Cd:** The relationship of the member to the subscriber
- **Curr Cap Amt:** The current month calculated capitation amount
- **Retro Cap Amt:** The retroactive calculated capitation amount
- **Total Cap Amt:** The total Current Month and Retroactivity capitation
- **Member Provider Eff Date:** The date the member first became effective for the Primary Dental Office
- **Member Provider Term Date:** The date the member terminated from the Primary Dental Office, if applicable

**Act Cd:** A code representing changes in membership status for the Primary Dental Office.

To assist the Primary Dental Office in locating members, the bottom of each page gives the last name of both the first and last members listed on that page.

The end of the report shows the total number of members in the office, total current capitation amount, total retroactivity capitation amount, and a grand total of the total capitation amount.

Explanations of Relationship Codes and Action Codes will also be found at the end of this report.

An example of the Provider Capitation Statement can be found at the end of this section.

**Provider Retroactive Adjustment Statement**

This report details any payments made for Retroactivity for all members for the month. Retroactivity may be calculated for Retroactive Group Capitation Rate Changes, Retroactive Enrollment Changes, or Retroactive Provider Specialty Category Changes. Retroactivity may be a positive or negative amount.

The following information is itemized on the Retroactivity Report:

- **Name:** Last Name, First Name of the member
- **Member ID:** The member’s contract ID (Social Security Number or Unique Member Identifier)
- **Plan Number:** The member’s plan type
- **Type:** Type of contract (employee only, employee and spouse, etc.)
- **Date of Birth:** The member’s date of birth
- **Sex:** The member’s sex
- **Rel Cd:** The relationship of the member to the subscriber

Explanations of Relationship Codes and Action Codes will also be found at the end of this report.
Mbr Mo:  Member months, the total number of months for which retroactivity is being applied

Retro Cap Amt:  The retroactive calculated capitation amount

Member Provider Eff Date:  The date the member first became effective for the Primary Dental Office

Member Provider Term Date:  The date the member terminated from the Primary Dental Office, if applicable.

Act Cd:  A code representing changes in membership for the Primary Dental Office

At the end of the report, a total line will be listed showing the total for each type of retroactive capitation, total capitation, and a grand total of the retroactive capitation amount.

Explanations of Relationship Codes and Action Codes will also be found at the end of this report.

An example of the Provider Retroactive Adjustment Statement can be found at the end of this section.

Provider Capitation Summary
This report details the Current and Retroactive Capitation Amounts, and the total Members by Benefit Schedule Name for a Provider’s Office for the Capitation Period.

The following information is itemized on the Retroactivity Report:

Group Number:  The nine-digit number assigned to the group by United Concordia

Group Name:  The group name

Cap Cmp Mth:  Method of calculating capitation, whether by age, member or type contract

Age Cat:  Age category, for groups that capitate the member by age, this column will display the appropriate age ranges

Contract Count:  Number of contracts that are assigned to this office

Mem Count:  The number of members in the contract

Curr Cap Rate:  The total current capitation rate for the group/benefits schedule name

Total Current Cap Amt:  The total current capitation amount

Total Retro Cap Amt:  The total calculated retroactive capitation amount

Total Cap Amt:  Total capitation amount calculated for a group/benefit schedule name

Bene Schd:  The member’s plan type

Total:  The total number of members and capitation amount calculated for a group

Grand Total:  The grand total number of members and capitation calculated for the provider for all benefit schedules within a group

An example of the Provider Capitation Summary can be found at the end of this section.

Eligibility Change Report
This report details all New Members Added, Members Transferred into the Primary Dental Office, Members Terminated from the Primary Dental Office, Members Transferred Out of the Primary Dental Office, and Member Benefit Schedule Changes which have occurred since the last Capitation Period.

New Members Added:  This section details the new members added since the last capitation period

Name:  Last Name, First Name of the member

Member ID:  The member’s contract ID (Social Security Number or Unique Member Identifier)

Plan Number:  The member’s plan type

Date of Birth:  The member’s date of birth

Sex:  The member’s sex

Rel Cd:  The relationship of the member to the subscriber
Member Provider Eff Date:  The date the member first became effective for the Primary Dental Office

Transfers In:  This section details members transferring into the Primary Dental Office from another Primary Dental Office

Terminated Members:  This section details members whose coverage has terminated

Member Provider Term Date:  The date the member terminated from the Primary Dental Office, if applicable

Transfers Out:  This section details members who have transferred their coverage to another Primary Dental Office

Benefit Schedule Transfers:  This section details members' whose benefit schedules have changed

Copay Schedule:  The member’s copayment schedule

Transfer from Bene Schedule:  The benefit schedule the member used to have as part of his/her benefits

Transfer to Bene Schedule:  The benefit schedule the member now has as part of his/her benefits

Explanations of Relationship Codes will also be found at the end of this report

An example of the Eligibility Change Report can be found at the end of this section.

Provider Protection Plan (excluding Auto)
United Concordia offers a risk-sharing Provider Protection Plan (PPP) for Primary Dental Offices participating in its Capitated Dental Network. The Provider Protection Plan is designed to act as a “safety net” for the participating provider.

PPP Overview
Under the PPP, Participating Primary Dental Offices are guaranteed a minimum reimbursement level for services performed for plan members. The reimbursement is based on a percentage of the United Concordia Maximum Allowable Charge (MAC) Schedule.

The PPP is based on member utilization. Claim information can be reported to us electronically or by using a standard claim form. Missing or incomplete information alters the outcome and integrity of the report. Please be sure to submit claim information in a timely manner. Prompt submission will ensure proper reimbursement. You should receive the report approximately 45 days after the close of the quarter. A summary report is sent to your office on a quarterly basis.

Utilization Reports and any PPP payments due a provider will be mailed four (4) times a year, one after each settlement period.

• The four (4) settlement periods are:
  » January 1 through March 31
  » April 1 through June 30
  » July 1 through September 30
  » October 1 through December 31

• PPP is calculated based on member utilization for the current settlement period plus member utilization from the previous three (3) settlement periods.
ADMINISTRATION

• PPP payment is based on a dentist’s Production Percentage. The Production Percentage for the period is determined by adding the total amount of capitation, member copayments for services performed and all additional payments received, and then dividing this total by the MAC value of the services performed. If the Production Percentage falls below the PPP guaranteed percentage, the provider may be entitled to a Protection Plan payment.

Requirements for PPP Participation

• United Concordia must receive all utilization (encounter) data before the 15th of the month following the end of a settlement period.
• Encounters should be submitted every two (2) weeks.
• To be eligible for a payment under the United Concordia PPP a Primary Dental Office must be open to new patients.

How PPP Is Calculated

The PPP is calculated and paid quarterly based on a rolling four quarters (current quarter plus the three previous quarters).

Each quarterly report gives you the quarterly revenues (cap and copay) and the quarterly percent of MAC value, as well as total revenues for the past twelve months. PPP payments are paid based on the percentage of MAC for the twelve month revenue. Offices are excluded from any applicable PPP’s for the period the office is on “hold”.

To calculate the quarterly PPP reimbursement:

• Add the patient copayments + the total capitation + any PPP adjustments during the last twelve months. This equals your total revenue for the last twelve months.
• The total revenue divided by the total MAC value of services provided will give you the percentage of MAC.
• If this percentage is less than your PPP guarantee, a supplemental payment to bring you to the guarantee percentage will be made.

Examples

PPP Guarantee at 68%
PREV ADJ $0.00
COPAY $2,500.00
CAP $2,500.00
REV $5,000.00
MAC $10,000.00
% OF MAC 50%
ADJ $1,800.00

PPP Guarantee at 70%
PREV ADJ $0.00
COPAY $2,500.00
CAP $2,500.00
REV $5,000.00
MAC $10,000.00
% OF MAC 50%
ADJ $2,000.00

PPP Guarantee at 75%
PREV ADJ $0.00
COPAY $2,500.00
CAP $2,500.00
REV $5,000.00
MAC $10,000.00
% OF MAC 50%
ADJ $2,500.00

Provider Protection Plan (Auto Only)

Auto PPP Overview

The United Concordia Auto Program PPP is designed to protect against adverse utilization that may occur in an individual office. United Concordia guarantees payment equal to 65% of the current Provider Protection Schedule. Submission of utilization (encounter) data is crucial in determining PPP payment.

Requirements for Auto PPP Participation

PPP payments will be made only to those offices that:
• Submit complete utilization within thirty (30) days following the month services were rendered. (United Concordia reserves the right to audit all utilization data submitted.)

• Remain open to all new United Concordia Auto subscribers.

• Remain in compliance with quality assurance guidelines including, but not limited to, review of office grievances.

• Agree to PPP schedules approved by United Concordia.

How Auto PPP Is Calculated
All the income received from the United Concordia Auto Program (including capitation and supplemental payments) and copayments from the patients will be calculated. United Concordia will compare this income to 65% of the PPP schedule to determine if additional payments are due your office. The Provider Protection payments will be distributed at six-month intervals.

United Concordia Auto will provide PPP payments in those cases where it has been determined that compensation (capitation, supplemental payments and patient copayments) is below 65% of the Provider Protection schedule.
### UNITED CONCORDIA COMPANIES, INC.

**RUN DATE:** MM/DD/YY  
**PROVIDER CAPITATION STATEMENT**  
**REPORT:** TCP0510R-001  
**FROM:** MM/DD/YY  **TO:** MM/DD/YY

**PROVIDER NUMBER:** XXXXXX  **SITE:** XXX  **NAME:** XXXXXXXXXXXXXXXXXXXX

| NAME         | MEMBER ID | PLAN NUMBER | GROUP NUMBER | DATE OF BIRTH | REL | M | CURR AMT | RETRO CAP | TOTAL AMT | MEMBER EFF | PROVIDER MEM | PROVIDER TERM | ACT CD E | CD | CAP AMT | T T CAP | AMT | CAP AMT | DATE   |
|--------------|-----------|-------------|--------------|---------------|-----|---|---------|-----------|-----------|------------|-------------|--------------|------------|--------|--------|---------|--------|-----|---------|--------|
| XXXXXXXXXX   | XXXXXXX   | 99999999    | XXXX         | 999999-9999   | X   | M | 999.99  | 999.99    | 999.99    | MM/DD/YY   | MM/DD/YY    | XX        |
| XXXXXXXXXX   | XXXXXXX   | 99999999    | XXXX         | 999999-9999   | X   | M | 999.99  | 999.99    | 999.99    | MM/DD/YY   | MM/DD/YY    | XX        |
| XXXXXXXXXX   | XXXXXXX   | 99999999    | XXXX         | 999999-9999   | X   | M | 999.99  | 999.99    | 999.99    | MM/DD/YY   | MM/DD/YY    | XX        |
| XXXXXXXXXX   | XXXXXXX   | 99999999    | XXXX         | 999999-9999   | X   | M | 999.99  | 999.99    | 999.99    | MM/DD/YY   | MM/DD/YY    | XX        |

**TOTALS**  
**ELIGIBLE MEMBERS:** 4

**REL CD:** SUB (SUBSCRIBER), SPO (SPOUSE), DEP (DEPENDENT), HAN (HANDICAPPED)  
**ACT CD:** A (ADD), C (CHANGE), TI (TRANSFER INTO OFFICE), RA (RETRO ADD), RT (RETRO TERM), RI (RETRO TRANS IN), RO (RETRO TRANS OUT)  
**CAPITATION COMPENSATION METHOD CODE:** A (AGE), C (CONTRACT), M (MEMBER), T (TYPE CONTRACT)

XXXXXXXXXXXX-XXXXXXXXXXXX
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<th>MEMBER ID</th>
<th>TYP</th>
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<th>RETRO CAP AMT</th>
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REL CD: SUB (SUBSCRIBER), SPO (SPOUSE), DEP (DEPENDENT), HAN (HANDICAPPED)
ACT CD: A (ADD), C (CHANGE), TI (TRANSFERRED INTO OFFICE), RT (RETROACTIVE TERMINATION), RO (RETROACTIVE TRANSFER OUT OF OFFICE)
## UNITED CONCORDIA COMPANIES, INC.

### PROVIDER CAPITATION SUMMARY

**RUN DATE:** MM/DD/YY  
**REPORT:** TCP0520R-01

**FROM:** MM/DD/YYYY TO: MM/DD/YYYY

**PROVIDER NUMBER:** XXXXXX  
**SITE:** XXX  
**NAME:** XXXXXXXXXXXXXXXX

<table>
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<tr>
<th>GROUP NUMBER</th>
<th>GROUP NAME</th>
<th>CAP CMP TYP MTH CONT</th>
<th>AGE CAT</th>
<th>CONT COUNT</th>
<th>MEM COUNT</th>
<th>CURR RATE</th>
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<th>TOTAL CAP AMT</th>
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REL CD: SUB (SUBSCRIBER), SPO (SPOUSE), DEP (DEPENDENT), HAN (HANDICAPPED)
SPECIALTY REFERRAL GUIDELINES

Quick Reference
The following information is a quick reference to United Concordia’s specialty referral guidelines:

- United Concordia will not pre-authorize DHMO Specialty referrals
- Referral to a prosthodontist is not a covered benefit

All referrals must be made to a United Concordia contracted specialist. If a United Concordia specialist is not in the area, contact Customer Service at (866) 357-3304.

- Specialty Care Referral Forms must be completed for members with specialty referral benefits and a copy must be submitted to United Concordia
- If the procedure is not a covered benefit, the member is responsible for all charges to the specialist
- Anterior and bicuspid root canal therapy is the responsibility of the Primary Dental Office
- Pedodontic referral ends on the child’s 7th birthday
- Orthodontic extractions are not a covered benefit

If additional Specialty Care Referral Forms are required, please call make photocopies from the examples included in this guide or download additional copies from our Web site at www.unitedconcordia.com.

If the procedure is within the scope of a general dentist or is a non-referable procedure, the Primary Dental Office may be liable for the cost of the referral. The specialist will be paid and the cost of the referral will be deducted from the Primary Dental Office’s capitation payment.

Referral Process
During the course of treatment, your office may determine that treatment requires referral to a specialist. When this occurs, refer the patient to one of the specialists in the Concordia PLUS Specialist Directory. The listing is updated and sent to you quarterly, but the list is subject to change. To confirm dentist participation, visit the Find a Dentist tool at www.unitedconcordia.com or contact the specialist directly. When making a referral, your office must complete the Specialty Care Referral Form.

Maryland offices are required to use the Maryland Uniform Dental Consultation Referral Form. District of Columbia and Virginia offices should use the standard form.

Examples of both versions can be found in the forms section at the end of this guide and on United Concordia’s Web site at www.unitedconcordia.com.

Note: It is also necessary to complete the appropriate Referral Form when referring to a participating specialist within the same office.

Each patient must be supplied a copy of the completed referral form to give to the specialist at the time of his or her specialty appointment. It is recommended that the Primary Dental Office keep a copy of the completed referral form in the patient’s chart.

Referring To A Specialist When One Is Not Available In The Area
If there is no specialist in the area, contact Customer Service for assistance. An area is defined as a location(s) within 30 miles of the patient’s residence in urban areas and within 50 miles of the patient’s residence in rural areas (or within community and industry standards if no licensed specialty care dentist exists within 50 miles).

When contacting Customer Service, please be prepared to provide the following:

- Name and address of the specialist to whom the member is being referred
- Services being referred
SPECIALTY REFERRAL GUIDELINES

• Tooth number(s)
  A specialty referral form should be completed by the Primary Dental Office and sent with the member to the specialist. The member should receive treatment as requested by the Primary Dental Office and is only responsible for applicable copayment.

The specialist should complete the appropriate specialty referral form and indicate dates of service and cost for treatment. The form should be sent to:

United Concordia Companies, Inc.
Attn: Claims Processing
PO BOX 69422
Harrisburg, PA 17106-9422

Endodontic Specialty Referral Guidelines
The Primary Dental Office is expected to perform routine endodontic therapy on anterior and premolar teeth. If a member is referred to an Endodontist for procedures that do not meet the specialty referral criteria, the Primary Dental Office’s capitation will be reduced by the amount paid to the Endodontist. Do not complete a Specialty Referral/Claim Form for non-covered procedures.

The following may be referred to a participating Endodontist:
• Any unusual conditions that the Primary Dental Office feels are beyond his/her competence (must obtain approval from United Concordia prior to referral)
• Molar root canals (permanent teeth)
• Apicoectomies
• Internal or external root resorption (anterior and posterior)
• Endodontic retreatment (anterior and posterior)
• Anterior and bicuspid teeth with the following documented conditions:
  » Calcified or dilacerated canals
  » Curved roots
  » Unusual circumstances
  » Molar endo performed on the same date of service as anterior or bicuspid endo
  » States “had to go through the crown”

United Concordia will not reimburse the Endodontist for the following:
• Services that do not meet the specialty referral criteria or have not received prior approval from United Concordia
• Teeth with poor prognosis (member should be referred back to the Primary Dental Office, who should inform the member that the plan does not cover treatment of teeth which have a poor prognosis)
• Teeth requiring root canal therapy as a result of an accident or trauma that may be covered by another insurance, (e.g., major medical, liability insurance, etc.)

The Primary Dental Office should not complete a Specialty referral/Claim Form in these situations.

Oral Surgery Specialty Referral Guidelines
The Primary Dental Office is expected to perform simple extractions. A simple extraction of an erupted tooth is defined as one that does not require elevation of a mucoperiosteal flap and/or sectioning of the tooth. The tooth can be removed from the socket using forceps and leverage or rotation. A surgical extraction of an erupted tooth is defined as an extraction that requires elevation of mucoperiosteal flap and removal of bone and/or section of tooth.

If a member is referred to an Oral Surgeon for procedures that do not meet the specialty referral criteria, the Primary Dental Office’s capitation will be reduced by the amount paid to the Specialist. Do not complete a Specialty Referral/Claim Form for non-covered procedures.

The following may be referred to a participating Oral Surgeon:
• Any unusual conditions that the Primary Dental Office feels are beyond his/her competence (must obtain approval from United Concordia prior to referral)
• Molar endo performed on the same date of service as anterior or bicuspid endo
• States “had to go through the crown”
• Surgical extraction
• Alveoloplasty
• Four or more simple extractions to be done at the same session
SPECIALTY REFERRAL GUIDELINES

• Simple extraction when done in conjunction with a surgical extraction at the same session
• Removal of impacted teeth
• Surgical removal of residual roots
• Frenulectomy (frenectomy or frenotomy), frenuloplasty

United Concordia will not reimburse the Oral Surgeon for the following:
• Services that do not meet the specialty referral criteria or do not have prior approval from United Concordia
• IV sedation or general anesthesia (unless an eligible benefit)
• Teeth requiring extraction as a result of an accident or trauma that may be covered by any other insurance, (e.g., major medical, liability insurance, etc).

The Primary Dental Office should not complete a Specialty Referral/Claim Form in these instances.

• Extraction of third molars in orthognathic surgery cases

Pediatric Specialty Referral Guidelines

The Primary Dental Office must complete the Specialty Referral/Claim Form specifying the services referred to the Pediatric Specialist. If a member is referred to a Pediatric Specialist for procedures that do not meet the specialty referral criteria, the Primary Dental Office’s capitation will be reduced by the amount paid to the Pediatric Specialist. Do not complete a Specialty Referral/Claim Form for non-covered procedures. Coverage for referral to a Pediatric Specialist ends on a member’s 7th birthday.

The following may be referred to a participating Pediatric Specialist:
• Children under 7 years of age who:
  » Have extensive treatment needs
  » Cannot be managed in the Primary Dental Office due to lack of patient cooperation (behavior management problem)
  » Individuals, regardless of age, who are mentally/physically handicapped or medically compromised and cannot be treated in the Primary Dental Office (documentation from physician required to validate)

United Concordia will not reimburse the Pediatric Specialist for the following:
• Services that do not meet the specialty referral criteria or do not have prior approval from United Concordia
• Services for children 7 years of age or older who are not physically/mentally handicapped or medically compromised
**Periodontal Specialty Referral Guidelines**

The Primary Dental Office is expected to render comprehensive treatment for periodontal case types I & II. If a member is referred to a participating Periodontist for procedures that do not meet the specialty referral criteria, the Primary Dental Office’s capitation will be reduced by the amount paid to the Periodontist. Do not complete a Specialty Referral/Claim Form for non-covered procedures.

The following may be referred to a participating Periodontist:

- Any unusual conditions that the Primary Dental Office feels are beyond his/her competence (must obtain approval from United Concordia prior to referral)
- Consultations
- Scaling and root planing for periodontal case types III & IV
- Periodontal surgical procedures for periodontal case types III & IV and periodontal surgical procedures not related to periodontal case types:
  - Gingivectomy
  - Gingival Flap Procedure
  - Crown Lengthening
  - Osseous Surgery
  - Bone Replacement Grafts
  - Guided Tissue Regeneration
  - Soft Tissue Grafts
  - Distal Wedge Procedure
  - Full mouth debridement
  - Periodontal maintenance - Patient must have completed active periodontal treatment, (i.e., surgery and/or scaling and root planing). Full mouth debridement is not considered active treatment.

United Concordia will not reimburse the Periodontist for the following:

- Services that do not meet the specialty referral criteria or do not have prior approval from United Concordia
- Treatment of periodontal case types I, II & V
- Teeth with poor prognosis (member should be referred back to the Primary Dental Office, who should inform the member that the plan does not cover treatment of teeth which have a poor prognosis)

The Primary Dental Office is expected to provide the Periodontist with the following when referring periodontal case types III & IV:

- Periodontal classification
- Diagnostically acceptable full mouth series of radiographs
- Full mouth periodontal charting, which includes pocket measurements and mobility

The Periodontist is expected to perform a reevaluation of the patient’s periodontal status following completion of scaling and root planing for periodontal case types III & IV.

**Periodontal Disease Classifications**

The American Academy of Periodontology (AAP) uses periodontal case types to describe disease progression. These case types and descriptions are listed below and should be used in determining when the member is eligible for referral to a Specialist (periodontal case types III & IV) or should be treated in the Primary Dental Office (periodontal case types I & II). While use of Periodontal Case Types is convenient for DHMO referrals, the AAP has new classifications of periodontal disease. Periodontal case type V, refractory periodontitis, is not referrable.

**Treatment of refractory periodontitis by other than prophylactic maintenance is not covered. The member should be informed that the plan does not cover treatment of teeth that have a poor prognosis.**

**Case Type I - Gingivitis**

Inflammation of the gingiva characterized clinically by changes in color, gingival form, position, surface appearance, and presence of bleeding and/or exudate.

**Case Type II - Early Periodontitis**

Progression of the gingival inflammation into the deeper periodontal structures and alveolar
bone crest, with slight bone loss. There is usually a slight loss of connective tissue attachment and alveolar bone.

**Case Type III - Moderate Periodontitis**
A more advanced stage of early periodontitis (see above) with increased destruction of the periodontal structures and noticeable loss of bone support, possibly accompanied by an increase in tooth mobility. There may be furcation involvement in multi-rooted teeth.

**Case Type IV - Advanced Periodontitis**
Further progression of periodontitis with major loss of alveolar bone support usually accompanied by increased tooth mobility. Furcation involvement in multi-rooted teeth is likely.

**Case Type V - Refractory Periodontitis**
Includes those patients with multiple disease sites that continue to demonstrate attachment loss after appropriate therapy. These sites presumably continue to be infected by periodontal pathogens no matter how thorough or frequent the treatment provided. Also includes those patients with recurrent disease at single or multiple sites.
Access to Care
United Concordia requires that participating providers adhere to the American Dental Association (ADA) Guidelines with respect to a patient’s access to care. The ADA states, “The Primary Dental Office shall be responsible, at all times, for maintaining emergency coverage, provided in accordance with the guidelines of the ADA or applicable law.”

Some means of contacting the dentist, or a covering dentist, must be available to the member at all times.

A covering dentist is acceptable provided the dentist is licensed in the state he/she practices and has agreed to accept the member’s respective copayments as payment in full. If such an arrangement is not reached, the assigned general dentist will be responsible for any claim arising from the incident.

It is unacceptable to send members to another participating provider in the United Concordia Network without that provider’s prior consent or to instruct members to contact United Concordia.

Should you encounter problems with emergency coverage, please contact Professional Relations for assistance.

The following are a few acceptable suggestions concerning emergencies:

- A recorded message that provides members with a phone number or pager number that can be used to contact their dentist or his/her designee, who will in turn, contact the dentist.
- Call forwarding or twenty-four (24) hour answering service.
- Any other approved device or method that ensures that there is a prompt response to meet the emergency needs of patients.

Failure to comply with these ADA standards for emergency coverage may result in a claim that will be the responsibility of the primary dental office. Office emergency procedures will be verified during the Quality Assessment Review.

No-Show & Lateness (Code D9999)

- Each plan administered by United Concordia includes/COVERS Code D9999, by report.
- The copayment listed is for every fifteen (15) minutes that a patient is late up to the time allotted for his/her appointment.
- You will find a sample letter included in the forms section of this guide that you may wish to use for patients who tend to be late or cancel without giving twenty-four (24) hours notice. This letter is intended to assist your office in preventing abuse of what should be considered by the patient to be a professional appointment.
- You may decide to use this letter as an exception, stating that this time is excused, but that you will be charging “X” amount of dollars according to the member’s Schedule of Benefits for future occurrences. Please copy this letter onto your office letterhead prior to mailing.

Cost of Metal

- Charges for the use of precious (high noble) or semi precious (noble) metal are not included in the co-payment for crowns, bridges, pontics, inlays and onlays. The decision to use these materials is a cooperative effort between the dentist and the patient, based on the professional advice of the dentist. Dentists are expected to charge no more than an additional $125 or the cost of gold alloy per dwt used for these materials, whichever is lower.

Note: Some National Plans do not allow for a metal charge to the member and for some plans the charge is less than $125.

Missing Teeth

A pre-existing missing tooth does not prevent the patient from receiving restoration.
• When a patient is missing teeth on both sides of the mouth (except for a continuous anterior segment) or has non-contiguous missing teeth in the same arch, either upper or lower jaw, he/she is not eligible for fixed partial denture restoration as a plan benefit. Also, when anterior and posterior teeth are missing, either upper or lower jaw, the patient is not eligible for fixed partial denture restoration. The term “missing teeth” does not include 3rd molars for the purpose of this guideline.

• In addition, missing teeth do not apply to this guideline if the resultant space is closed to less than ½ of the width of a bicuspid.

• The patient is eligible for fixed partial denture restoration when there is a posterior, one-sided space involving one or two teeth, and a mesial and distal tooth adjacent to the space (whether or not they are both utilized as retainers -- e.g. cantilever fixed partial denture), and if the retainer teeth and occlusion are clinically healthy. In the upper and lower anterior segments, defined as cuspid to cuspid (#6-11 or #22-27), the patient is eligible for a fixed partial denture when any number of contiguous incisor teeth are missing (#’s 7-10 or 23-26) and the retainer teeth and occlusion are clinically healthy. When not dentally necessary (i.e., replacing existing serviceable removable partial dentures or when crowning of unrestored retainer teeth is necessary and the occlusion is stable; tooth has been missing for an extended period of time and is no longer drifting), a patient is not eligible for a fixed partial denture. An exception to this guideline is the case of an aesthetically critical missing tooth or teeth, such as the anteriors and bicuspids. Please check the copayment schedules for appropriate member charges.
not necessarily constitute full mouth rehabilitation. However, based on other case-by-case factors, such as the number and location of fixed crown units necessary and an alteration of the vertical dimension of occlusion, a case may involve full mouth rehabilitation.

- Procedures requiring appliances or restorations necessary to alter occlusion, change vertical dimension of occlusion, provide restorative equilibration or kinesiology are excluded from coverage.

- In case of a disagreement between the member and the dental office regarding the diagnosis of full mouth rehabilitation, the United Concordia Dental Director will render a second opinion.

- When crowns and fixed partial dentures are excluded in relationship to full mouth rehabilitation, other services, such as surgical services, preventive services, fillings and non-restorative services are not excluded from coverage due to the full mouth rehabilitation.

**Pediatric Full Mouth Rehabilitation/Reconstruction**

- Restorative treatment becomes excluded from coverage when stainless steel crowns are required to treat more than 50% of the existing dentition. If full mouth rehabilitation is necessary, only the stainless steel crowns are not covered as a result of the full mouth rehabilitation. Other services, such as surgical services, preventive services, fillings and non-restorative services are covered due to the full mouth rehabilitation.

- When 50% or less of the existing teeth are decayed, dental care is a covered benefit regardless of cause of decay.

- There are no limitations for crowns. Therefore, if a 13-year-old (or younger) has the clinical need and the doctor prescribes the crown, then it is covered and the member is responsible for the applicable copay and metal fee. The policy also applies to root canal therapy, build-ups and posts.

- United Concordia’s DHMO plans are not subject to any time limitations, such as the standard 5-year limitation, for the replacement of crowns and fixed partial dentures. Therefore, members can be provided with a replacement at their plan copay and cannot be billed up to the dentist’s full charge for these services.

**Emergency Coverage**

A patient in need of emergency care displays symptoms of bleeding, fever, infection, loss of tooth, pain, severe discomfort or swelling. United Concordia’s participating dental offices are required to provide coverage for all members on a 24-hour, 7-days per week basis. The dental office must have someone on staff to receive a call should an emergency occur. If the emergency occurs after regular business hours, an answering machine with a telephone number of the dentist on call or an answering service must be available so a dentist can be notified as soon as possible. The dentist must answer the member’s call within 4 hours, and appoint the member within 24 hours. If the office does not provide for emergency care, the office may be financially responsible for the cost of palliative treatment. Upon United Concordia’s confirmation that emergency care was not available, the cost of the palliative treatment may be deducted from the assigned dentist’s capitation check.

**Out of Area Emergency Coverage**

- Services performed by a dentist other than the Member’s primary dentist are not covered, unless the Member is at least 50 miles away from his/her primary dentist’s office and has a problem that requires emergency treatment.

- Examples of emergencies include bleeding, fever, infection, loss of tooth, pain, severe discomfort or swelling. Treatment from a non participating dentist is limited to palliative treatment that will alleviate the immediate discomfort. Reimbursement may be limited to a maximum payment pursuant to the member’s benefit schedule.
Coordination of Benefits
Coordination of benefits is a means of determining responsibility for payment when an eligible member is covered by two different dental care programs. The combined coverages should be “coordinated” to pay up to 100% of the eligible expenses within the limits of both programs and is not to exceed the total expense incurred.

In order to determine which plan is primary, the following rules have been established.

- If the other plan does not have a COB provision similar to this one, then that plan shall be primary.
- If both plans have COB provisions, the plan covering the patient as a subscriber is determined before those of the plan which covers the patient as a dependent.

Dependent Child/Parents Not Separated or Divorced
The rules for the order to benefits for a dependent child when the parents are not separated or divorced are as follows:

- The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year.
- If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
- The word “birthday” refers only to month and day in a calendar year, not the year in which the person was born.
- If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

Dependent Child/Separated or Divorced Parents
If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- First, the plan of the parent with custody of the child
- Second, the plan of the spouse of the parent with custody of the child
- Third, the plan of the parent not having custody of child
- If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan.
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above in Section titled Dependent Child/Parents Not Separated or Divorced.

Active/Inactive Patient

- For actively employed patients and their spouses over the age of sixty-five (65) who are covered by Medicare, United Concordia shall be primary.
- When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, this rule will be ignored.

Miscellaneous

- If none of these rules apply, then the contract which has continuously covered the patient for a longer period of time shall be primary.
COBRA

• The plan covering an individual as a COBRA continues will be secondary.

Examples:
Two DHMO plans, regardless of which is primary versus secondary and assuming the Primary Dental Office participates in both plans.

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<td>Member Co-payment under second DHMO Plan:</td>
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The patient should be charged in accordance with the lesser of the two co-payment schedules. In this example, the patient is responsible for a $300.00 co-payment.

DHMO Plan is Primary and the Indemnity Plan is Secondary

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The Primary Dental Office should report the patient's co-payment and their normal fee to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan ($200.00) and their co-payment. If the service is not covered by the Primary Dental Office, then that fact should be communicated to the secondary carrier.

<table>
<thead>
<tr>
<th>Dentist is a Specialist</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Member Co-payment under DHMO Plan:</td>
<td>$300.00</td>
</tr>
<tr>
<td>Indemnity Plan Pays:</td>
<td>-$150.00</td>
</tr>
<tr>
<td>Balance:</td>
<td>$150.00</td>
</tr>
<tr>
<td>Specialist Guarantee with United Concordia:</td>
<td>$350.00</td>
</tr>
</tbody>
</table>

The specialist should report the patient co-payment as specified by the DHMO plan ($300.00) to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan ($150.00) and their co-payment. In this example, the patient is responsible for a $150.00 co-payment.

The specialist should then submit a claim for additional payment to United Concordia. Additional payment from United Concordia will not be made to the specialist if the combined payment ($300.00) from the patient ($150.00) and the indemnity plan ($150.00) to the specialist is equal to or greater than the amount guaranteed to the specialist ($350.00) by United Concordia. In this example, there would be an additional payment from United Concordia to the specialist for $50.00.

Examples:
Indemnity plan is Primary and the DHMO plan is Secondary

<table>
<thead>
<tr>
<th>Dentist is a Primary Dental Office</th>
<th></th>
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<tbody>
<tr>
<td>Regular Office Fee:</td>
<td>$500.00</td>
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<tr>
<td>Indemnity Plan Pays:</td>
<td>-$400.00</td>
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<tr>
<td>Balance After Indemnity Payment:</td>
<td>$100.00</td>
</tr>
<tr>
<td>Member Copayment under DHMO Plan:</td>
<td>$350.00</td>
</tr>
</tbody>
</table>

The Primary Dental Office should submit the regular office fee ($500.00) to the Indemnity Carrier. The patient pays the difference between the fee submitted to the indemnity plan and the amount reimbursed by the
The specialist should submit the regular office fee ($500.00) to indemnity carrier. The patient pays the difference between the fee submitted to the indemnity plan and the amount reimbursed by the indemnity plan ($500.00) or their co-payment according to the DHMO plan ($300.00), whichever is less. In this example, the patient is responsible for a $300.00 co-payment.

The specialist should then submit the regular office fee in the form of a claim for additional payment (if applicable) to the capitated plan to include an explanation of benefits (EOB) from the indemnity plan. If the secondary plan is a United Concordia plan, there will not be any additional payment to the specialist if the combined payment ($300.00) from the patient ($300.00) and the primary indemnity plan to the specialist is equal or greater than the amount guaranteed to the specialist ($400.00) by United Concordia. In this example, there would be an additional payment from United Concordia to the specialist for $100.00.

Clarification of Fractures and Dislocations

Purpose/Scope: To clarify the plan exclusion involving “fractures and dislocations.”

Policy/Procedure:
- The term “fractures” in the plan exclusion stating “fractures and dislocations” does not refer to fractures of the teeth or any part of the teeth or restorations of the teeth or prostheses replacing teeth. These types of fractures are covered to the extent that the necessary reparative procedures are covered on the specific plan.
Crown lengthening will only be recognized and billable when performed on a separate date of service than the crown preparation or impression and only when adequate time has elapsed for proper healing. While the adequate time for healing may vary from patient to patient and based on the extent of the surgery performed, a reasonable period of time for healing after crown lengthening is generally no less than two weeks and usually six to eight weeks.

Extraction vs. Root Canal Therapy (RCT)
Purpose/Scope: To define the alternative procedures and coverage when a tooth needs RCT.

Policy/Procedure:
- When the pulp of a tooth is infected and/or exposed to the oral environment, there are essentially only two options for treatment: RCT or extraction.
- Instances arise when a patient will request the dentist extract a tooth that can be saved with RCT and restoration, when the RCT and restoration will yield a favorable prognosis. While extraction of an infected tooth may be a viable alternative, the dentist may not be willing to recommend extraction due to his or her personal or professional ethics involving extraction of a salvageable tooth.
- If extraction of a salvageable tooth is against the dentist’s personal or professional ethics and is not recommended by the dentist, then the dentist can do one of the following:
  » Agree to perform the extraction as a covered benefit at the listed copayment to the patient, or
  » Refuse to treat the patient for that service and, if necessary, dismiss the patient from the practice.
  » The dentist cannot charge the patient a higher fee (than the listed copayment) if the extraction is rendered.

The dentist’s objection to performing the extraction should be clearly explained to the patient and documented in the patient chart.

Fixed Partial Denture Placement
Purpose/Scope: To clarify and define when an existing fixed partial denture is covered to be replaced with another fixed partial denture and when it is not covered.

Policy/Procedure:
- Fixed partial dentures are covered on the plans as outlined in the respective benefits schedules and the Provider Operations Reference guide.
- The coverage for fixed partial dentures is subject to the diagnosis and prescribed treatment of the Primary Dental Office. If the Primary Dental Office does not prescribe the treatment and the Primary Dental Office’s determination meets with appropriate standards of care, then the replacement fixed partial denture is not covered.
- Many instances arise when a member has an existing, failing fixed partial denture. In general, if a member presents to the Primary Dental Office with a fixed partial denture, the member is covered to have that fixed partial denture replaced with another fixed partial denture. However, exceptions exist to that general rule, including, but not necessarily limited to the following (the policies also apply to initial placement of a fixed partial denture):
  » If the existing or proposed fixed partial denture has a span that exceeds the limits of coverage as outlined in the specific benefit schedule. For example, if the fixed partial denture is more than 4 units in the posterior or 6 units in the anterior.
  » If the span of the proposed fixed partial denture, due to loss of additional teeth or necessary redesign, will exceed the limits of coverage as outlined in the specific benefit schedule. For example, if the fixed partial denture is more than 4 units in the posterior or 6 units in the anterior.
» If the proposed fixed partial denture is in an arch where there are other missing teeth (with the exception of missing 3rd molars or teeth extracted for orthodontic purposes where the resultant space is closed to less than ½ of the width of a bicuspid). If these other missing teeth have been replaced by another existing fixed partial denture and that fixed partial denture is serviceable and not in immediate need of replacement, then the pontic teeth of that existing fixed partial denture shall be considered as natural teeth for the purpose of benefit determination.

» If the prognosis of the existing retainer teeth is not acceptable or will not meet acceptable standards of care to be used as retainers. This prognosis may be affected by both the restorative requirements of the proposed fixed partial denture and/or the periodontal health of the teeth and existing bone support.

• The proposed fixed partial denture involves materials, attachments or services that are excluded from the plan and are required due to the restorative needs of the patient. This provision includes implants, unless the specific benefit schedule covers implants and related services.

• In instances when a fixed partial denture is not covered, the covered benefit will be for a removable prosthesis, if prescribed and provided by the Primary Dental Office and any necessary crowns on the retainer tooth/teeth as required due to the restorative needs of the tooth/teeth. However, this treatment must meet professionally recognized standards. A removable prosthesis is covered only if there is sufficient retainer support and stability in the arch.

• As with all dental restorations, the patient's periodontal status and health must support the prosthesis. The patient must have periodontal conditions successfully treated prior to coverage for prosthetic restorations and provision of those restorations.

Full Mouth Debridement
Purpose/Scope: To establish a policy and define the criteria for full mouth debridement.

Policy/Procedure:
• Full mouth debridement is an accepted dental procedure defined in the CDT code definitions, procedure code D4355, as the removal of subgingival and/or supragingival plaque and calculus. This is a preliminary procedure and does not preclude the need for other procedures. This procedure may be necessary more than once and may require multiple visits to complete. The CDT describes this procedure as full mouth debridement to enable comprehensive periodontal evaluation and diagnosis.

• By definition and description, full mouth debridement is an initial procedure to be performed before a comprehensive examination can be rendered due to the extent of plaque and calculus deposits present on the teeth. When necessary, full mouth debridement must be rendered before a definitive diagnosis can be made of oral conditions, except for conditions requiring emergency treatment.

• Full mouth debridement will not be recognized and is not appropriate to describe the procedure if rendered or planned after a definitive diagnosis has been made for other conditions or services, not including emergency services.

• If full mouth debridement is rendered after a definitive diagnosis has been made for non-emergency conditions or after non-emergency treatment has been rendered, then the full mouth
debridement will be considered integral to either a prophylaxis or any necessary and justified root planing or both.

- These requirements for full mouth debridement to be a preliminary procedure do not apply to X-rays; therefore, number and type of X-rays may be appropriate to take before or after full mouth debridement is rendered.

Incision & Drainage (I&D) of Abscess on Same Date of Service as RCT, Extraction or Periodontal Surgery

**Purpose/Scope:** To establish and describe general criteria regarding the coverage for I&D of an abscess on the same date of service as an RCT, extraction or periodontal surgery. As a general rule, I&D is included in and is a part of root canal therapy, extraction or periodontal surgery by virtue of the fact that any necessary drainage of an abscess is established by the other surgical procedure. However, exceptions exist to this rule, as described below.

**Policy/Procedure:**

- When root canal therapy, extraction or periodontal surgery services are performed in the presence of an undraining abscess, drainage of that abscess is usually established by the surgical service rendered. Therefore, in most cases, I&D of abscess is integral to other surgical procedures rendered.

- There are instances when an abscess extends into spaces of the head and neck area that are not immediately part of the tooth, teeth or area from which the abscess originated. In these instances, adequate drainage of the abscess cannot be established by the other surgical procedure alone. Therefore, I&D of an abscess is covered as a separate procedure in these instances, in addition to the other covered surgical procedure(s) rendered.

- In order to appropriately charge for I&D of an abscess rendered on the same date as other surgical procedures, the treating dentist must maintain detailed documentation indicating the need for the I&D, including a description of the anatomical spaces involved in the abscess. In addition, the documentation should include a surgical report of where and how the abscess was drained. Failure to do so may not provide adequate justification for the I&D being a separate service and may constitute unbundling of services and charges.

Liability for Non-Covered Services

**Purpose/Scope:** To establish a policy and procedure for handling patient complaints or disputes involving the provision of services which are not covered on the schedule of benefits.

**Policy/Procedure:**

- It is the standard of care for dentists to present to their patients all reasonable treatment alternatives when developing treatment plans to meet their patients’ needs. Some of these treatment alternatives may not be covered on a specific schedule of benefits.

- In the event that a non-covered service is proposed or rendered, and the member has a complaint or dispute involving the non-covered service, the plan generally has no responsibility and assumes no liability for the resolution of the complaint or dispute. Any complaint or dispute involving a non-covered service is between the patient and the dentist since the non-covered service is not a part of the plan contract with the patient.

- Upon the plan’s receipt of a complaint or dispute involving a non-covered service, the Dental Director will determine the appropriate actions, if any, to be taken by the plan to address any systemic issues that may be identified by the complaint or dispute. Such actions may include, but not necessarily be limited to, focused review of the identified provider for any adverse trends of complaints, results of previous chart reviews, etc. However, the resolution of the specific issues addressed in the complaint or dispute involving the non-covered service is...
the responsibility of the patient and the provider, with the possible exception of quality of care issues that may have been raised by the complaint and any other issues that may be identified that are not necessarily part of the complaint.

- Any issues identified in the complaint dispute that are not directly related to the non-covered service will be addressed in a manner consistent with the plan’s complaint/grievance process. For example, if the complaint or dispute involves a non-covered service as well as alleged unsanitary conditions, then the issue regarding the alleged unsanitary conditions will be addressed through the plan’s normal complaint/grievance process.

### Pulpal Debridement

**Purpose/Scope:** To identify the distinction between an open and drain or pulpectomy (gross pulpal debridement), emergency service, pulpotomy and the actual start of root canal therapy.

**Policy/Procedure:**

- When a tooth has irreversible pulpitis, the tooth is in need of either extraction or RCT. Frequently, irreversible pulpitis is associated with severe pain. On an emergency basis, the tooth will be opened and the pulpal material will be removed. This procedure is frequently referred to as “open and drain” or “pulpectomy.” Pulpectomy can be defined as gross pulpal debridement.

- The procedure code used for an open and drain procedure is frequently D9110, palliative treatment. However, the CDT also describes a code, D3221, “Gross Pulpal Debridement,” which is also a proper code to use for an open and drain or pulpectomy procedure.

- On plans that do not have code D3221, open and drain or pulpectomy (gross pulpal debridement) is covered as D9110.

- Regardless of what the provider calls the procedure, the emergency treatment of opening a tooth to relieve pain is covered as procedure D9110 or D3221.

- If open and drain or pulpectomy (gross pulpal debridement) is performed on the same date and by the same provider as root canal therapy, then the open and drain or pulpectomy (gross pulpal debridement) procedure is integral to the root canal therapy and cannot be billed in addition to the root canal therapy.

- Open and drain or pulpectomy (gross pulpal debridement) is not the start of root canal therapy. Open and drain or pulpectomy (gross pulpal debridement) is the removal of the contents of the pulp area of the tooth for the relief of pain and then placing a cotton pellet and a temporary filling in the tooth. Many times, a medication may also be placed in the tooth. Root canal therapy involves the sequential filing of the canals of the roots to working length and size, then filling the canals with an inert material. If this filling has not occurred, then the root canal therapy has not started. Open and drain or pulpectomy does not constitute treatment in progress. The American Dental Association recognizes open and drain or pulpectomy (gross pulpal debridement) and root canal therapy as two separate procedures by virtue of the fact that separate procedure codes exist.

- Open and drain, pulpectomy and gross pulpal debridement are not the same procedure as a pulpotomy (D3220). Pulpotomy is a distinctly different procedure that, by definition, is not performed in conjunction with root canal therapy and cannot be billed as the start of root canal therapy or as an emergency procedure preceding root canal therapy.
Optional or Alternative Services

Purpose/Scope: To establish and describe general criteria regarding how to administer optional or alternative services for members in contracted dental offices.

Policy/Procedure:

- All dental treatment and coverage for that treatment is subject to the diagnosis, treatment planning and recommendations of the treating dentist.
- Most dental conditions can be treated by two or more separately suitable dental procedures.
- Any dental procedure listed on a schedule of benefits is a covered benefit if recommended or rendered by the treating dentist. Any dental service not listed on the schedule of benefits is not a covered benefit. However, instances may arise when a contemplated service is not a covered benefit while a comparable covered service is separately suitable to treat the same condition. Also, instances may arise when a cosmetic upgrade is either requested or may enhance a patient's appearance.
- If a treating dentist offers to a patient an optional or alternative service that is not listed on the patient's benefit schedule while a separately suitable service is listed on the benefit schedule, then the dental provider must also offer the covered service to the patient at the listed copayment. This type of treatment planning is an integral part of providing informed consent. If the patient accepts the optional or alternative service, then the provider may charge the patient an additional fee in excess of the listed copayment. The additional fee should be computed using the difference in the provider's usual fees for the covered service and the usual fees for the non-covered service. Additional charges for cosmetic upgrades to covered crowns or fixed partial dentures are not covered by the plan and the patient is responsible for the upgraded fee(s). Examples include, but are not limited to, porcelain margins for teeth in the cosmetic zone of the mouth, upgraded ceramic materials and computer aided crown fabrication (single visit crowns or CAD/CAM crowns). Both the covered service and the optional or alternative service must meet professionally acceptable standards of care and have a scientific basis for their recommendation. When applicable, the patient must always be given a covered option to meet his/her needs. Failure to do so, or inappropriately charging in excess of the listed copayment, is a violation of state regulations and may result in the requirement for a refund to the patient of all excessively charged fees or a backbill of the same.
- When optional or alternative treatment is offered to and accepted by the patient, there should be clear documentation in the patient file that a clinically acceptable service was offered to the patient but that an optional or alternative service was chosen.
- In cases involving treatment when there is no clinical need (i.e., rendered in the absence of pathology or absence of trauma), the treatment is not covered and there is no coverage allowance to be given for optional or alternative treatment. An example is cosmetic dentistry that replaces satisfactory restorations with cosmetic restorations. However, caution is advised to help prevent violation of the Dental Practice Act, namely overprescribing of treatment or prescribing of unnecessary treatment. Patients must be informed of all alternatives for treatment, including the alternative of no treatment and its resultant consequences, if any.
- The term “preventive crown” is frequently used by dental offices to render a crown on a tooth as a non-covered service. However, the term “preventive crown” is an oxymoron in that to prevent something like fracture of the tooth, healthy tooth structure must be removed to prepare the tooth for a crown. Therefore, if a dentist recommends and/or renders a crown on a tooth, the dentist is, by default, indicating that the crown is clinically necessary, and is therefore, covered. If the crown is not clinically necessary, then the dentist should not render the
crown, and if rendered (as a service that is not necessary), the dentist may be over-prescribing treatment, in violation of the Dental Practice Act [B&P Code, Section 1680(p)]. United Concordia does not recognize the term “preventive crown.” A crown is either necessary and appropriate (and covered) or is not necessary and is not appropriate.

- Craze line(s) in the enamel of a tooth is not an appropriate indication for the need for a crown or other restoration, in the absence of other appropriate indicators, such as pain on percussion. Therefore, patients should not be prescribed crowns or other restorations in teeth solely because the teeth have craze lines. If a tooth is cracked and is symptomatic, a crown or other restoration may be appropriate to treat the tooth, and if rendered is covered, if the crown or restoration is listed on the patient’s Schedule of Benefits and is not otherwise excluded. In such a case, the reason for the crown should be clearly documented in the patient chart and the dental office cannot charge more than the applicable copayment for the crown or other restoration (plus any applicable metal fee).

The following is an optional form that may be used by dental offices when providing optional treatment (such as cosmetic crowns).
Optional or Alternative Services Treatment Plan & Financial Responsibility Form

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Covered Treatment</th>
<th>Non-Covered or Enhanced Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tooth #</td>
<td>CDT Code</td>
<td>Procedure Description</td>
</tr>
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Patient Name: ____________________________ Date: ______________
I have been given the option of my plan benefit for covered and non-covered services. The non covered treatment options above, including all fees, have been fully explained to me. The non covered treatment option is my sole financial responsibility. The co-pay for any precious crown(s) includes $125 noble metal charge.

Patient Signature (Parent or Guardian, if patient is a minor) ____________________________ Date

Dentist or Authorized Office Staff Signature ____________________________ Date
Orthodontic Records

Purpose/Scope:
To establish consistency in the application and administration of the fees to be charged for orthodontic records.

Policy/Procedure:
• DHMO plans indicate coverage for orthodontic records. This coverage for records includes “… all diagnostic procedures, including, but not limited to: cephalometric, full mouth X-rays, models and treatment plan.” [sic]
• For the purposes of benefit administration and copayment application, the term “diagnostic” applies only to the initial records required for the orthodontic provider to arrive at a diagnosis and formulate a treatment plan.
• Mid-treatment (or progress) records and post-treatment records are not included in the definition of “diagnostic” and are, therefore, not covered.
• If mid-treatment and/or post-treatment records are requested by the orthodontic provider, the member is responsible for payment of the provider’s normal fees. If the member refuses to receive or pay for this service, then the provider may refuse treatment if these records are normally a part of the provider’s records protocol.

Alternate Orthodontic Services
Invisalign, OrthoClear and other similar orthodontic treatment mechanisms can be alternative methods to conventional orthodontic appliances (in certain circumstances) to treating an orthodontic condition. The plan covers comprehensive orthodontic treatment at the specific copayments listed on the benefit schedule. As with treatment of other dental conditions, the plan covers completed dental procedures as listed in the benefit schedule.

The methods by which the dentist completes those procedures are subject to the diagnosis, clinical opinion and expertise of the treating dentist. However, the dentist and patient should discuss all methods of treatment that are reasonable for the patient’s condition. Therefore, if Invisalign, OrthoClear or other similar appliances are the only method of orthodontic treatment performed by your office and offered to the eligible patient and no other exclusions or limitations apply, then those services are covered at the corresponding copayment listed on the benefit schedule. If the patient is offered a conventional, comprehensive orthodontic treatment plan at the listed copayment, but chooses an alternative treatment plan including appliances such as Invisalign or OrthoClear, then the dentist may charge the additional fee. However, the price differential must be agreed-upon between the dentist and patient.

Documentation of the offer of the covered service at the applicable copayment must be evident in the patient chart for any additional fees to apply to the alternative service. The requirement to offer conventional orthodontic treatment may be satisfied by offering referral to a participating orthodontist. Such an offer, like all alternatives, should be clearly documented in the patient’s chart.

Periodontal Irrigation Services

Purpose/Scope: To establish and describe general criteria regarding how to administer services involving irrigation of periodontal pockets with medicinal or antimicrobial solutions.

Policy/Procedure:
• Services involving irrigation of periodontal pockets with medicinal or antimicrobial solutions that are delivered clinically by a predictable or controlled method are an acceptable practice by providers under certain conditions.
• Instances arise when the application of medicinal or antimicrobial solutions may be beneficial for the periodontal health of the patient in terms of response time for healing after periodontal therapy, such as root planing or curettage.
With benefit plans that do not cover irrigation, the provider may charge a reasonable fee for this service. While it is not feasible to place a specific limit on the allowable fee for irrigation without a contractual agreement, a range of acceptability may be developed. A range of acceptability for irrigation is approximately 15% to 40% of the provider's usual quadrant fee for scaling and root planing. The irrigation fee may be charged per quadrant. The proper procedure code to report periodontal irrigation services is D9630.

A provider should not charge an additional fee for irrigation unless the member is fully informed of the need for the irrigation service and the consequences of not having the irrigation service rendered.

A provider should not refuse to offer or to perform conventional periodontal therapy (e.g., scaling and root planing) if the member refuses to receive irrigation or to accept the charges for irrigation. The member is entitled to receive the benefit(s) listed on the plan, as dictated by clinical need, without being required to accept or pay for irrigation. However, an exception to this rule may exist for patients who are immuno-compromised, have diabetes, have conditions that cause delayed healing response or other similar conditions.

It is highly recommended that the provider have the patient sign an informed consent form and a financial agreement, indicating accepted services and charges, before treatment is rendered.

**Prophylaxis**

**Purpose/Scope:** To establish a policy and definition for prophylaxis.

**Policy/Procedure:**

- Prophylaxis is defined as scaling and polishing to remove plaque, calculus and stains from the enamel surfaces of the teeth. It may require multiple appointments, depending on the patient’s needs. It is a definitive procedure for the removal of deposits on the enamel surfaces of the teeth. A prophylaxis consists of:
  - Removal of all coronal calculus and plaque, including scaling of all coronal tooth surfaces associated with calculus (see Paragraph 3.5 below)
  - Coronal polishing of all tooth surfaces, including removal of stains
  - Flossing of all interproximal tooth surfaces that cannot be accessed by other instrumentation

- A child prophylaxis is defined as a cleaning of the primary or transitional (mixed) dentition. If no primary teeth are present, the patient should be treated as an adult. A child prophylaxis rarely involves significant calculus and is usually performed by localized (spot) scaling, coronal polishing and flossing. The length of time necessary for a child prophylaxis varies, depending upon many factors.

- While prophylaxis is a preventive procedure, it is rendered in the presence of disease by virtue of the fact that plaque and calculus are present. The presence of plaque and calculus indicates that disease is also present, which leads to gingival inflammation or gingivitis and eventually periodontal disease.

- Prophylaxis is not synonymous with coronal polishing. Coronal polishing is only one of several components of a prophylaxis.

- Prophylaxis removes coronal plaque and calculus. Some of this calculus may be below the level of the gums (i.e., subgingival) and still be defined as coronal calculus. If calculus is on root surfaces, then root planing may be the proper procedure for calculus removal. If calculus is subgingival but adhered to enamel surfaces, then prophylaxis is the proper treatment (subsequent to full mouth debridement, if applicable), and any so-called “root planing” that is rendered is integral to the prophylaxis.
• Prophylaxis may be rendered in the sequence prescribed by the treating dentist, as long as that sequence meets with acceptable standards of care. In other words, the treating dentist may postpone a prophylaxis until such time that more urgent or critical procedures are completed to protect and maintain the overall health of the patient’s mouth.

The amount of time necessary to perform a prophylaxis is dependent upon several factors. This treatment time may average 20-30 minutes. However, other tasks may enter into the prophylaxis treatment visit to increase the total appointment time, such as taking of X-rays, oral evaluation (including pocket depth charting) or patient consultation. Some of the factors that affect actual prophylaxis treatment time include, but are not limited to:

• The efficiency of the operator
• The type of instrumentation used
• The degree of access to the tooth surfaces to be cleaned
• The amount of bleeding during the procedure
• The number of teeth in the mouth
• The amount and tenacity of any stains present
• The amount and consistency of the calculus present
• The length of time the calculus has been present (length of time since the last prophylaxis)

Prophylaxis involving implants is not a part of a standard prophylaxis procedure, uses specialized instruments and procedures, and is described by a separate procedure code.

Root Planing

Purpose/Scope: To establish a policy for the number of quadrants of root planing that can be rendered in the same mouth on the same date of service, as well as some specific criteria defining root planing.

Policy/Procedure:

• Root planing involves instrumentation of the root surfaces of each affected tooth in a quadrant to thoroughly remove plaque and calculus and leave a smooth root surface. This procedure can be very time-consuming and fatiguing (for both patient and health professional), depending on the amount of deposits and the number of teeth involved. It is generally performed and reported per quadrant. Though, if fewer than 4 teeth are involved in a quadrant, the root planing service must be reported as a partial quadrant, using the appropriate CDT code.

• Root planing can be rendered using hand instruments or an ultrasonic scaler, or both. If either method is used, the result must include calculus-free, smooth roots. Either a hygienist or a dentist can perform these procedures.

• Root planing is usually performed using local anesthesia. Some patients can tolerate this procedure without anesthesia, but this phenomenon is rare. Some health professionals will utilize topical anesthesia instead of injectable anesthesia. Topical anesthesia is not as effective as injectable anesthesia, but may make the procedure tolerable for some patients.

• Root planing is performed when deposits (e.g., calculus) are present on root surfaces. When calculus is present only on enamel surfaces (i.e., the root surfaces are involved in the periodontal attachment and are not exposed to the sulcus of the pocket), root planing cannot be rendered, as there are no roots available to be instrumented and planed. In such an instance the proper procedure to remove the deposits is prophylaxis or full mouth debridement.
• Pocket depth alone is not a definitive indicator of the need for root planing. Pockets can form in the absence of bone loss due to inflammation of the gingival tissues, and are termed pseudo-pockets. Bone loss must be present to justify root planing.

• Due to the requirements for this procedure, rendering more than two quadrants of root planing in the same mouth on the same date of service will not be recognized. Exceptions to this rule may be made based on the documentation of the case (e.g., an extended appointment with the consent of the patient due to reasons such as long travel time or distance to the office or medical conditions, such as premedication requirements).

• If more than two quadrants of root planing are rendered in the same mouth on the same date of service, without acceptable documentation, then all of the root planing is integral to a prophylaxis.

The amount of time necessary to perform a quadrant of root planing is dependent upon several factors. Some of the factors that affect treatment time include, but are not limited to:

• The efficiency of the operator
• The type of instrumentation used
• The degree of access to the root surfaces to be planed
• The degree of anesthesia, if any
• The number of teeth present in the quadrant
• The amount of root surfaces to be planed per tooth (dictated by the degree of periodontal attachment loss)
• The amount of bleeding during the procedure
• The amount and consistency of the calculus present on the roots
• The length of time the calculus has been present on the roots
• Root planing will not be recognized for a patient under the age of 25, unless specific documentation exists justifying the need. If rendered, without justification, the root planing or curettage is integral to a prophylaxis. Justification must include demonstrated bone loss in the quadrant being treated. If a full quadrant of root planing is being reported, then at least four teeth must demonstrate bone loss.

• Root planing performed on the same date of service as a prophylaxis is integral to the prophylaxis.

Sterilization Fees
Purpose/Scope: To establish a definitive policy prohibiting providers from charging sterilization or related/similar fees to covered plan members.

Policy/Procedure:
• Charging of sterilization fees, operatory preparation fees, additional office visit fees, OSHA compliance fees or other related or similar fees are prohibited. These types of fees are surcharges, which are prohibited by the Knox-Keene Act, which regulates the administration of dental benefits for health care service plans.

• Sterilization fees, operatory preparation fees, additional office visit fees, OSHA compliance fees or other related or similar fees are unbundled charges, which are not permitted on United Concordia plans. The costs reflected in these types of fees are part of standard required and expected office procedures and are part of the overhead costs of conducting or running a dental office and treating patients. Sterilization and infection control is a component of the covered dental procedure(s) rendered.

Synonymous Terms, Generic Terms and Miscellaneous Procedures
Purpose/Scope: To establish and describe general criteria regarding benefit administration and interpretation involving dental services that can be described in two or more different ways and the proper use of miscellaneous procedures.
Policy/Procedure:

- There are many types of dental services that can be described in two or more different ways. While the descriptions may vary, giving the appearance of different procedures, the actual clinical procedures associated with the varying descriptions may be identical.

- The current CDT codes and descriptions are the basis on which the plan’s dental benefits are described and defined. If a procedure is not defined by a current CDT code, then that procedure is not recognized by the plan as a valid procedure and will be rolled into the most applicable CDT-described procedure for the purpose of determining benefits or lack of benefits. Exceptions to this rule may be made based on the actual description of the procedure (to be) rendered. Any exceptions must meet with acceptable standards of care.

Examples of possible exceptions may include, but not be limited to:

  » “Fixed partial denture repair,” which can involve a large variety of differing procedures to obtain the desired result.
  
  » “Crown build-up under an existing crown,” which can be a very involved process that is different from a standard build-up process and different from a standard crown recementation. This procedure is usually rendered due to a crown coming loose and when a standard recementation will not be effective due to inadequate remaining tooth structure.

- If a procedure is listed on a schedule of benefits, that procedure is covered if prescribed by the treating dentist and if not otherwise limited on the schedule of benefits. If a listed procedure is covered and can be described in another way, then that procedure is covered regardless of how the procedure is described.

Examples of synonymous or generic terms include, but are not limited to:

  » The term “oral evaluation” is synonymous with oral examination, intraoral examination, oral or intraoral diagnosis, and any other term that is related to or involved in the evaluation of the oral health of the patient to arrive at an appropriate diagnosis.
  
  » The term “denture” refers to any type of denture (e.g., partial, full, immediate, etc.), unless otherwise specified.
  
  » The term “pulp cap” refers to and is synonymous with any procedure that involves the placement of a material in the tooth for the purpose of generating a barrier between the tooth cavity and the pulp tissue.

For coverage purposes, any brand name is synonymous with the comparable generic name, such as (but not necessarily limited to):

- Coverage for composite resin includes coverage for all brand names of composite resin materials, if no other options are given.
  
- Coverage for crowns and fixed partial dentures includes coverage for all brand names of crown materials, if no other options are given.
  
- Coverage for dentures includes coverage for all brand names of denture materials and types of denture teeth, if no other options are given.
  
- The term “full mouth debridement” is synonymous with gross scaling or any other clinical procedure (to be) rendered with technical components, as described by CDT.
  
- Miscellaneous procedure codes are to be used only when an acceptable procedure rendered for the patient is not adequately described by a standard, valid procedure code. The use of miscellaneous procedure codes for the purpose of unbundling, generating more fees through surcharges (prohibited by state regulations), or similar purposes are prohibited. The use of obsolete procedure codes for the purpose of generating more fees is also prohibited.

A dentist cannot create new procedure descriptions and invalid codes, thus
generating more fees for treatment because those descriptions or codes are not listed on the covered schedule of benefits. Such activity is prohibited by state regulation.

**Treatment That Yields a Poor Prognosis**

**Purpose/Scope:** To define the governing procedures and coverage for the restorative treatment of a tooth that has a poor prognosis.

**Policy/Procedure:**
Instances arise when a patient will request that the dentist treat a tooth (usually with a restoration) that has a poor prognosis. Examples of this type of situation include, but are not limited to:

- Restoration of a tooth that should be extracted.
- Replacement of missing teeth with a prosthesis (a fixed partial denture or removable partial denture) when the retainer teeth have inadequate supporting bone.
- Periodontal treatment with the intent of saving the remaining teeth when the remaining teeth are hopeless and in need of extraction.
- Rendering a service to a patient that yields a poor prognosis may be below the standard of care. The dentist is not obligated to perform services for the plan, even if requested by the patient, that are not within the standard of care.
- All listed services on a benefit schedule must be prescribed by the participating dentist to be covered. A patient is not entitled to coverage for a listed service if that service is not prescribed by the participating dentist.
- If the participating dentist agrees to perform a service listed on the benefit schedule and requested by the patient, that service is a covered benefit. The dentist cannot charge any additional fee (such as his/her usual fee) to the patient for such services. In addition, the dentist is assuming all responsibility and liability for that service. By the dentist performing a service, the dentist is prescribing that service.
- If the patient requests a service that yields a poor prognosis, the dentist may refuse to provide that service to the patient and dismiss the patient from his or her practice, if necessary, if the patient refuses to follow the dentist’s prescribed course of treatment.

**Unbundling of Services**

**Purpose/Scope:** To establish the protocol prohibiting the unbundling of covered services.

**Policy/Procedure:**

- Unbundling is a term used to describe when a procedure, normally billed as a whole, is divided into the individual components that make up the entire global procedure (e.g., a full mouth set of X-rays being divided into individual films for billing purposes; or a denture procedure being divided into billings for impressions, bite trays, try-ins, lab processing, adjustments, etc.).
- Unbundling of covered services is not permitted, as defined by state regulation.
- If a procedure is listed on a schedule of benefits as covered, then all related components of that procedure, as defined by current CDT procedure codes or by acceptable clinical practices, are also covered. A partial list of examples includes, but is not limited to:
  - If oral evaluations (examinations) are listed as covered, then all components of comprehensive oral evaluation, including periodontal charting and diagnosis, are also covered and included in the coverage for the oral evaluation. Periodontal charting or probing or any other diagnostic information necessary to arrive at a diagnosis is an integral part of oral evaluation.
  - If fillings are listed as covered, then all components of the filling procedures, including bonding procedures, are also covered and included in the coverage for fillings.
» If a prosthetic procedure is listed as covered, then all related components of the covered prosthetic procedure, such as impressions, opposing models, custom trays, try-ins, etc., are also covered and included in the coverage for the prosthetic procedure.

» If a crown or fixed partial denture is listed as covered, then all components of the covered crown or fixed partial denture, such as such as impressions, opposing models, custom trays, try-ins, gingival retraction, temporary restoration, etc., are also covered and included in the coverage for the crown or fixed partial denture.

» If root canal therapy is listed as covered, then all related components of the root canal therapy, such as temporary restorations, medicaments, irrigation materials, interim treatment X-rays and final X-rays, etc., are also covered and included in the coverage for the root canal therapy. Pulp testing is an integral part of the oral evaluation to arrive at a diagnosis.

Unless specifically listed in a schedule of benefits, charging of operatory preparation fees, sterilization fees, additional office visit fees, OSHA compliance fees, instrument tray set-up fees or other related or similar fees is prohibited. Sterilization and infection control is a component of the covered dental procedure(s) rendered.

Vertical Dimension of Occlusion (VDO)
Purpose/Scope:
To establish a definitive policy and definitions regarding changes in the VDO.

Policy/Procedure:
• VDO is very simply defined as the point in the jaw’s movement at which the posterior teeth come together in their normal biting position.
• Loss of VDO occurs over time due to wear and tear on the teeth, excessive grinding (bruxism), weak tooth structure (enamel or dentin disorders), or bone loss with denture wearers or denture wear itself. VDO may be increased using various methods.
• Dental treatment that involves a change in VDO entails a degree of difficulty beyond that of standard dental treatment. In addition, changing the VDO involves risks including, but not limited to, TMJ and related disorders.
• If the dental treatment involving fixed crowns or fixed partial dentures alters the VDO (by removing all posterior vertical occlusal stops), then the treatment is not covered on the plan.
• With crowns and fixed partial dentures, VDO is altered any time that the full mouth treatment plan involves a sufficient number of crown or fixed partial denture units such that all positive posterior occlusal vertical stops are being affected on the occlusal plane. That is, if all teeth requiring crowns were prepared simultaneously, then all posterior occlusion would be temporarily removed. This temporary loss of occlusion may not necessarily involve the preparation of all of the posterior teeth.
• By necessity, the fabrication of a removable full denture and some removable partial dentures will establish a new VDO due to the fact that VDO is not defined as a specific point in an edentulous mouth. Rather, VDO is a range with removable full dentures and some removable partial dentures and is always slightly different with each remake in any given patient. Therefore, coverage for removable full denture treatment and some removable partial denture treatment is not excluded from coverage based on the change in VDO, except when the change in VDO is accomplished with the use of special appliances (such as temporary dentures or bite planes) or special techniques.
• If specific appliances or special techniques are used to change the VDO, the special appliances are temporary and are not covered (i.e., they have CDT codes that are not listed on the schedule of benefits). However, after the
appropriate time of wearing a temporary appliance, the final denture is a covered benefit, if not otherwise excluded or limited.

- If a change in VDO is attempted with a removable denture, but no additional appliances or special techniques are utilized as stated above in 3.5.1, then the denture is covered unless otherwise excluded or limited. The definition of VDO with removable full dentures also applies to removable partial dentures only when no natural positive posterior occlusal vertical stops are present in the mouth. Otherwise, if a natural positive posterior occlusal vertical stop is present, then any change in VDO attempted using the removable partial denture excludes the removable partial denture from coverage.

- If no change in VDO is attempted, then the removable partial denture is covered, unless otherwise excluded or limited.

- If no natural positive posterior occlusal vertical stops are present, then the removable partial denture cannot be excluded from coverage based on a change in VDO, unless special techniques or appliances are also used.

**Health Insurance Portability & Accountability Act (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates standards for electronic data interchange (EDI) and code sets, establishes uniform health care identifiers, and seeks protection for the privacy and security of patient data.

The overall objectives of HIPAA are to reduce paperwork, improve efficiency of health systems, and protect the security and confidentiality of electronic information. National Standards for electronic transactions are intended to encourage electronic commerce as health care providers will be able to submit the same HIPAA compliant transaction to any health plan in the United States and the health plan must accept it. There will no longer be hundreds of different formats.

**HIPAA Privacy**

The final HIPAA Privacy Rule was published in December 2000. Most health plans, clearinghouses and health care providers that are covered by this rule were required to comply by April 14, 2003. United Concordia is fully compliant with the HIPAA Privacy Rule. The intent of this law is to protect a person’s health information from unwanted, unauthorized and/or commercial uses without impeding the delivery of health care services or payment. United Concordia is committed to protecting our member’s privacy in accordance with all applicable Federal and State laws.

**HIPAA Security**

The final HIPAA Security Rule was published in February 2003. Most health plans, clearinghouses and health care providers that are covered by this rule were required to comply by April 20, 2005. United Concordia is fully compliant with the HIPAA Security Rule. The intent of this law is to protect the confidentiality, integrity and availability of electronic protected health information. United Concordia is committed to ensuring the security of our customers’ information in accordance with all applicable Federal and State law requirements.

**HITECH**

The American Recovery and Reinvestment Act of 2009 (ARRA) also known as the “Stimulus Bill” was enacted on February 17, 2009. ARRA contains extensive provisions that collectively are referred to as the “Health Information Technology for Economic and Clinical Health Act” or “HITECH Act”. These provisions include important changes to the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. The Department of Health and Human Services (HHS) is in the process of issuing regulations and other guidance, which will continue for several years. United Concordia has achieved compliance with the September 23, 2009 “Breach Notification
for Unsecured Protected Health Information Interim Final Rule” of the “HITECH Act” and will achieve compliance with all future HITECH provisions for which United Concordia is considered a covered entity as defined by HIPAA.
NATIONAL DENTAL POLICY
This section contains National Dental Policy information that applies to Standard Managed Care Dental Plans owned or managed by United Concordia Companies, Inc. This Policy applies to procedures that are a covered benefit. The member’s benefit schedule should be referenced to verify coverage for a specific procedure.

This information is confidential and proprietary. It cannot be reproduced in any form without written permission from United Concordia Companies, Inc.

General Policy Information
Explanation of Terms
There are some frequently used terms that appear throughout this document. An explanation of these terms and how they apply to United Concordia dental managed care plans is as follows:

- **Copayment**: Dollar amount member is responsible for according to their benefit schedule.
- **Eligible**: Procedure is a covered benefit.
- **Integral**: Procedure is not eligible for separate reimbursement; Primary Dental Office cannot charge separately for this procedure; member has no financial responsibility.
- **Not Covered**: Procedure is not a covered benefit; Primary Dental Office may charge their usual fee; member is financially responsible for this amount.

Payment Responsibility of Member
Any dental treatment necessitated by patient neglect, lack of patient cooperation or failure to comply with a professionally prescribed treatment plan that results in additional cost, will be the responsibility of the member.

If the Primary Dental Office recommends a diagnostic procedure or course of treatment to the member and the member refuses that recommendation, the member’s treatment record should be documented with this information and validated by the member’s signature.

Specialty Referrals
The Primary Dental Office is expected to perform general dental procedures. If a member requests to be referred to a Specialist for procedures that do not meet specialty referral criteria, the member is financially responsible for treatment. If the Primary Dental Office completes a referral form for procedures that do not meet specialty referral criteria, the Primary Dental Office’s capitation will be reduced by the amount paid to the Specialist.

Age Definitions
For procedures that differentiate between child and adult, (e.g., prophylaxis), a child is considered any individual age 12 and younger and an adult is considered any individual age 13 and older.

OSHA/Sterilization Fees
United Concordia does not permit members to be charged a separate fee for OSHA/sterilization.

Alternate Benefit Provision (ABP)
If a dental condition can be corrected or treated by means of a professionally acceptable procedure at a lower cost, the Primary Dental Office will only be responsible to provide the lower cost procedure. If a member chooses a more expensive service or treatment, the member is responsible for any cost in excess of what was allowed for the Alternate Benefit. This ABP would be administered by the Primary Dental Office as follows:

- **Crowns, Onlays and Inlays**: If an amalgam or resin filling will adequately restore a tooth, and the member and the Primary Dental Office decide on a more costly crown, onlay or inlay, the benefit allowed would be for the less costly filling. The member will be responsible for any cost in excess of the least expensive and professionally acceptable alternate treatment.

- **Fixed Partial Dentures**: If a removable partial denture will restore the dental arch satisfactorily, and the member and the Primary Dental Office decide on a more costly fixed partial denture, the benefit allowed would be for the less costly
removable partial denture. The member will be responsible for any cost in excess of the least expensive and professionally acceptable alternate treatment.

- **Removable Partial Dentures:** If a cast metal framework and resin base partial denture will restore the dental arch satisfactorily, and the member and the Primary Dental Office decide on a more costly precision appliance, the benefit allowed would be for the less costly RPD D5213 or D5214, and the member will be responsible for any cost in excess of the less expensive and professionally acceptable procedure. The member would be responsible for the listed copay plus the additional lab costs for materials and special procedures, (e.g. precision attachments).

- **Dentures:** If a member and Primary Dental Office decide on personalization of a denture or use of specialized techniques (such as an overdenture) instead of a standard denture, the benefit allowed would be for a standard denture. The member will be responsible for any cost in excess of the least expensive and professionally acceptable alternate treatment.

- **Crowns and retainers:** If a member elects a more expensive crown/retainer over the crown/retainer recommended by the doctor, the member will be responsible for the listed copay for the procedure and for the additional lab costs to fabricate the more expensive crown/retainer.

For example, a dentist recommends treatment for a crown of porcelain fused to predominantly base metal (D2751), but the patient is requesting a crown of porcelain fused to high noble metal (D2750).

The dentist may charge the copayment for the D2751 crown plus the difference in lab costs for fabricating the porcelain to high noble crown as opposed to the less expensive porcelain fused to base metal crown.

- **Subepithelial Connective Tissue Graft:** An allowance will be made for a free soft tissue graft. The provider and member will receive notification stating that any difference between the provider’s charge and the allowance for the free graft is the member’s responsibility.

### Integral Procedures

Payment for a dental procedure includes all necessary materials and services. Procedures that are an inherent part of another service are considered integral. Integral procedures should not be reported as separate procedures and are not billable to the member.

Integral procedures include, but are not limited to, the following:

- **Restorative Treatment:** Local anesthesia, use of all drugs, supplies, bases, liners, medicaments and bonding, occlusal and contact adjustment, polishing and refinishing of the restoration, preparation of gingival tissue, indirect and direct pulp capping, study models, impressions, laboratory procedures/fees, temporary restorative procedures, try-in visits, temporary and permanent cementation, additional posts and post removal.

- **Endodontic Treatment:** Radiographs (except radiograph taken to diagnose the need for endodontic therapy), local anesthesia, use of all drugs, supplies, medicaments, pulp tests, occlusal and contact adjustment, preparation of gingival tissue, removal of old root canal filling material for retreatment, sealing of pulp chamber, treatment of root canal obstructions.

- **Periodontal Treatment:** Assessment of home care, patient instruction and education, re-evaluation.

- **Oral Surgical Treatment:** Local anesthesia, suturing, suture removal, routine postoperative care, use of all drugs, supplies and medicaments.
**Responsibilities of the Primary Dental Office**

The primary dental office, hereafter referred to as the Primary Dental Office is responsible to:

- Comply with United Concordia Companies, Inc. primary dental office and specialty care quality standards.
- Arrange for emergency coverage when the office is closed. Failure to do so will result in a reduction of the Primary Dental Office’s capitation check.
- Arrange for coverage when the Primary Dental Office is on vacation. Failure to do so will result in a reduction of the Primary Dental Office’s capitation check.
- Verify patient eligibility and benefits prior to treatment.
- Evaluate patients’ dental needs.
- Apply United Concordia Policy for Managed Dental Care Plans and Schedule of Exclusions and Limitations.
- Discuss the treatment plan with the patient.
- Review patient responsibilities with the patient, including applicable copayments and services that may not be covered.
- Obtain patient signed consent prior to performing non-covered services.
- Provide eligible capitated general dentistry services.
- Refer only those eligible services as listed in the Specialty Referral Guidelines.
- Collect appropriate copayment(s) from the patient.
- Report covered services for eligible members to United Concordia via paper or electronic submission.
- Verify specialty care referral guidelines and coverage prior to making a referral.
- Complete the appropriate Referral Form when referring to a participating specialist within the same office.
- Refer appropriate services to a network specialist by completing the Authorization for Referral Services Form.
- Referral to an out of network specialist can be made if a network specialist isn’t available within a reasonable distance.
- Forward appropriate diagnostic radiographs to network specialist with completed Authorization for Referral Services Form.

**Diagnostic Policy for the Primary Dental Office**

**Oral Evaluations**

Oral evaluations should include, but are not limited to, the following integral procedures: complete medical and dental history, diagnosis and recommended treatment, determination of chief complaint, re-evaluation and documentation of original baseline information recorded from the comprehensive oral evaluation, medical history update, blood pressure check, recording of extraoral and intraoral hard and soft tissue examination, charting of restorations, caries, missing or unerupted teeth, oral cancer screening, occlusal relationship, periodontal status (PSR or periodontal charting), evaluation of oral hygiene status, and updating treatment plan (when applicable).

**Limited Oral Evaluation - Problem Focused**

- Integral to another oral evaluation provided on the same day by the same Primary Dental Office.

**Oral Evaluation for Patient Under Three Years of Age and Counseling with Primary Caregiver**

- Not eligible for patients over the age of three.

**Detailed and Extensive Oral Evaluation - Problem Focused, By Report**

- Integral to definitive service, palliative treatment, or another evaluation provided on the same day by the same Primary Dental Office.

**Comprehensive Periodontal Evaluation**

- Integral to another oral evaluation provided on the same day by the same Primary Dental Office.

**Intraoral - Complete Series (Including Bitewings)**

- Not eligible for patients under the age of five.
NATIONAL DENTAL POLICY

Periapical Radiographs
- One periapical is eligible within 30 days of root canal therapy when reported on the same claim by the same Primary Dental Office, all others are integral.
- Integral to full mouth series when taken on the same day by the same Primary Dental Office.

Cephalometric Radiographs
- Limited to one per patient, per lifetime.

Bitewings
- Integral to full mouth series when taken on the same day by the same Primary Dental Office.

Vertical Bitewings
- Processed the same as four bitewing radiographs.

Pulp Vitality Tests
- Integral to any definitive treatment.

Preventive Policy for the Primary Dental Office

Routine Dental Prophylaxis
- Integral when provided on the same day by the same provider as periodontal maintenance, scaling and root planing, or periodontal surgical procedures.

Topical Fluoride Treatment (Office Procedure)
- Eligible when a prescription strength fluoride product designed solely for use in the dental office is delivered to the dentition under direct supervision of a dental professional. Fluoride must be applied separately from the prophylaxis paste.

Topical Fluoride Varnish (Office Procedure)
- Application in a single visit, involving the entire oval cavity.

Sealants
- Eligible on a per tooth basis when applied to the occlusal surface of permanent first and second molars that exhibit deep grooves, pits and fissures.
- Teeth must be free of decay with no previous restorations on the mesial, distal or occlusal surfaces.
- Not eligible when reported with a mesial, distal, incisal or occlusal restoration on the same tooth.

Space Maintainers
- Eligible when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not or will never develop.
- Includes all adjustments for a period of 6 months.
- Repairs are not eligible.
- Recementations are integral by the same provider for a period of 6 months.
- Pedi partials are not eligible.

Removal of Fixed Space Maintainer
- Eligible when provided by a different office than the office that placed the space maintainer.

Restorative Policy for the Primary Dental Office

Pulp Capping
- Direct and indirect pulp capping are integral to all other treatment provided.

Amalgam Restorations
- Eligible only if the tooth is diseased or fractured.
- Includes repairs and replacement for a period of 12 months.
- Multiple restorations of the same tooth are considered one multi surface restoration (e.g., MO + DO = MOD).
- Integral to buildup/post and core provided on the same day by the same Primary Dental Office.

Resin Restorations – Anterior
- Eligible only if the tooth is diseased or fractured.
- Includes repairs and replacement for a period of 12 months.
• Resin restorations intended for cosmetic reasons are not eligible.
• Integral to buildup/post and core provided on the same day by the same Primary Dental Office.
• Replacement of an amalgam restoration with a resin material due to mercury sensitivity is not eligible.

Resin Restorations - Posterior
• Eligible only if the tooth is diseased or fractured.
• Includes repairs and replacement for a period of 12 months.
• Resin restorations intended for cosmetic reasons are not eligible.
• Multiple restorations of the same tooth are considered one multi surface restoration (e.g., MO + DO = MOD).
• Integral to buildup/post and core provided on the same day by the same Primary Dental Office.
• Replacement of an amalgam restoration with a resin material due to mercury sensitivity is not eligible.

Composite Resin Crowns – Anterior Permanent
• Eligible only if the tooth is diseased or fractured.
• Includes repairs and replacement for a period of 12 months.
• Resin restorations intended for cosmetic reasons are not eligible.

Crowns - Single Restorations Only
• Eligible for members age 14 and older.

Temporary Crown (Fractured Tooth)
• Eligible once per tooth, per lifetime.

Integral to routine crown fabrication. Prefabricated Stainless Steel Crowns
• Eligible for members through age 13.
• Integral when provided as a temporary crown during construction of a restoration for members age 14 and older.

Recement Inlay and Recement Crown
• Integral when provided within 12 months of insertion by the same Primary Dental Office.

Core Buildups and Post and Cores
• Not eligible when provided on primary teeth.
• Post and core provided on the same day by the same Primary Dental Office as a post and core/buildup will be merged to the most extensive procedure.

Pin Retention - Per Tooth, in Addition to Restoration
• Eligible on a per tooth basis (once per tooth), not per pin, when provided with a restoration.
• Core buildup provided on the same day by the same Primary Dental Office as the pin will be merged to the buildup.

Post Removal
• Not eligible as a separate service.

Recement Cast or Prefabricated Post and Core
• Integral when provided on same day by same Primary Dental Office as recement of a crown.
• Eligible once per tooth, per 12 month period.

Provisional Crown
• Not to be used as a temporary crown for routine prosthetic restoration.

Canal Preparation and Fitting of Preformed Dowel or Post
• Integral to root canal on same tooth, same day by the same Primary Dental Office.

Endodontic Policy for the Primary Dental Office

Pulpotomy
• Eligible only for primary teeth.
• Integral to endodontic therapy if provided by the same Primary Dental Office.
• When provided on permanent tooth, it is considered the start of endodontic therapy and is not eligible.

Pulpal Therapy (Primary Teeth)
• Eligible through age 5 on primary anterior teeth and through age 11 on primary posterior teeth.
Partial Pulpotomy for Apexogenesis
• Eligible only for permanent teeth.
• Eligible once per tooth, per lifetime.
• Integral on same day or within 180 days prior to root canal therapy by the same Primary Dental Office.

Endodontic Treatment
• Eligible once per tooth, per lifetime.
• Not eligible when provided on the same tooth by the same Primary Dental Office as an apexification.

Endodontic Retreatment
• Eligible once per tooth, per lifetime.

Apexification
• Not eligible when provided on the same tooth by the same Primary Dental Office on the same date or after the date of a root canal.

Pulpal Debridement
• Integral to root canal therapy or palliative emergency treatment on the same date by the same Primary Dental Office.

Apicoectomy
• Not eligible within 30 days following endodontic therapy (paid by exception only).

Pulpal Regeneration
• Only eligible on permanent teeth for patients under age 15.
• Eligible once per tooth, per lifetime.

Periodontal Policy for the Primary Dental Office

Periodontal Scaling and Root Planing
• Eligible once per 24 months in the same mouth area.
• Not eligible within 24 months following periodontal surgery in the same mouth area.
• Integral to comprehensive periodontal surgery provided in the same mouth area on the same day by the same Primary Dental Office.

Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis
• Eligible once per 24 months.
• Integral to scaling and root planing, periodontal maintenance or a routine prophylaxis provided on the same day by the same Primary Dental Office.

Periodontal Maintenance Procedures
• Eligible only following active periodontal treatment (periodontal surgical procedures or scaling and root planing).
• If more than one visit is required to complete the procedure, additional reimbursement is not eligible.
• Integral when provided on the same day as scaling and root planing or surgical periodontal procedures.

Removable Prosthodontics Policy for the Primary Dental Office

Denture Adjustments
• Integral when provided within the six months following insertion of the denture by the same Primary Dental Office.

Denture Rebase
• Integral when provided within the six months following insertion of the denture by the same Primary Dental Office.
• Rebasing an old denture to be used as a spare denture is not covered.

Denture Reline
• Integral when provided within the six months following insertion of the denture by the same Primary Dental Office.
• When provided with a denture rebase on the same day by the same Primary Dental Office, the service will merge to a denture rebase.

Tissue Conditioning
• Integral when provided at the same time as denture rebasing or relining.
Fixed Prosthodontics Policy for the Primary Dental Office

Fixed Partial Dentures, Buildups and Post and Cores
- Eligible only for members age 14 and over.

Recement Fixed Partial Denture
- Integral when provided within the 12 months following insertion by the same Primary Dental Office.

Oral Surgery Policy for the Primary Dental Office

Alveoloplasty
- Eligible when alveolar reshaping is required prior to the placement of a denture.
- Integral when provided in conjunction with extractions in an area involving three or fewer tooth sockets.

Incision and Drainage of Abscess - Intraoral Soft Tissue
- Integral when provided in conjunction with an extraction or root canal treatment on the same day in the same mouth area.
- Complicated I&D is not eligible.

Frenulectomy and Frenuloplasty
- Integral to periodontal surgery when provided on the same day in the same mouth area by the same Primary Dental Office.
- Frenuloplasty is integral to frenulectomy provided the same day.

Extraction Coronal Remnants – Deciduous Tooth
- Integral to extraction of the same tooth by the same Primary Dental Office.

Adjunctive General Policy for the Primary Dental Office

Palliative Emergency Treatment
- Eligible only when all of the following criteria are met:
  - Severe symptoms must occur suddenly and unexpectedly.
  - Immediate care required.
  - Immediate treatment was secured.
- Integral when provided in conjunction with definitive treatment.
- Eligible once per day by same Primary Dental Office.

Consultations
- A consultation is a diagnostic procedure provided by a dentist other than the Primary Dental Office.
- All consultations must be initiated by a Specialty Referral/Claim Form from the Primary Dental Office.
- Intra-practice referrals are not eligible when provided on same day as any procedure rendered by the Primary Dental Office.
- Consultation provided by the Primary Dental Office is not eligible and will be denied as a nonbillable service.
- Includes an oral evaluation.

Local/Block Anesthesia
- Integral to any treatment.
QUALITY ASSURANCE

Quick Reference
United Concordia has developed a Quality Assurance Program to monitor the quality of care provided to our members.

Prospective dental offices undergo an extensive initial assessment prior to being added to the United Concordia panel. The initial assessment includes facility review, patient safeguards, sterilization techniques, the recall system and the 24-hour policy for emergency availability.

Once an office is accepted onto the panel and becomes part of the United Concordia network, the office must participate in the Quality Assurance Program through scheduled on site audits, as determined by the Quality Assurance Protocol (usually once every 36 months, or more often if required).

The Quality Assurance Program is overseen by the Dental Director, who is a licensed dentist and knowledgeable in assessing quality of care.

All participating dental offices must comply with United Concordia’s quality assurance guidelines.

Quality Assurance Guidelines

Standards for Participation

Objective: To establish a Primary Dental Office and Specialty Care Network that provides high quality dental care for members.

Criteria:
To participate in the Concordia PLUS Network a dental practice should:

- Have providers who are appropriately licensed and are members in good standing in the profession.
- Have malpractice insurance.
- Demonstrate a commitment to the concepts of prevention and oral health maintenance.
- Have the potential to accommodate a minimum of 500 eligible participants without sacrificing service or quality of care.
- Uphold patient confidentiality in the office.
- Enter into a written Primary/Specialty Dental Office Agreement and accept the agreed reimbursement for providing or arranging for the provision of comprehensive dental care, including eligible specialty services.
- Demonstrate high ethical, moral, professional and clinical standards.
- Provide or arrange for comprehensive dental services, including eligible specialty care.
- Provide appropriate and adequate dental care in a cost efficient, caring and considerate manner.
- Establish routine office hours that meet the needs of the patient population and be available for emergency treatment during non-routine office hours.
- Schedule initial and routine appointments within four weeks (prime time appointments excluded), hygiene appointments within six weeks and emergency appointments during routine office hours must be available within 24 hours.
- Provide a mechanism to be reached at all times regarding the need for emergency treatment.
- Follow accepted standards for patient care, including protocols for care, radiology, patient records, sterilization and infection control.
- Cooperate with quality assurance, advisory, grievance, marketing and administrative activities to include credentialing and periodic office visits for assessment.
QUALITY ASSURANCE

Protocols for Patient Care

Patient Records
Objective: The patient record should be an organized, legible document for the documentation and maintenance of patient information. It should be readily accessible and easy to read and understand.

Criteria:
Each patient record should contain:
- An individual record for each patient.
- Registration information, (e.g., name, address, age, etc).
- Initial and complete health history with appropriate updates (medications listed).
- Medical alerts.
- Dental history and chief complaint.
- Informed consent.
- Soft tissue examinations.
- Dental charting.
- Periodontal screening evaluation.
- Complete periodontal evaluation for patients with evidence of periodontal disease.
- X-rays.
- Treatment plan.
- Progress notes.
- Evidence that patients have been seen for regular and timely recalls.
- Signature, initials or provider code of the dentist and/or hygienist annotating the record.

Sterilization and Infection Control
Objective: Patients and staff should be protected from infectious contaminants using the standard barrier techniques.

Criteria:
- All instruments and equipment should be sterilized by using an autoclave, dry heat or chemical vapor.
- Non-disposable instruments should be routinely sterilized between patients (including burs, endodontic files, handpieces, air/water tips).
- Process indicators should be utilized.
- Sterilization equipment should be tested at least once a week to ensure effectiveness and documentation should be kept.
- Disposable items/instruments should be discarded and not reused.
- Instruments and equipment that cannot be sterilized should be disinfected using an intermediate or higher level, hospital grade disinfectant.
- Sterilized equipment is to be pre- or post-bagged. Indicator tape or process indicators are to be used with each cycle (orthodontic pliers may be stored in closed cabinets without bag or wrap).
- To prevent cross contamination, stored instruments must remain bagged or covered until used for patient treatment.
- Disposable film holder devices are used or reusable devices should be cleaned and sterilized between use.
- EPA approved substances (which is classified as hospital grade disinfectant and tuberculocidal) should be used to disinfect exposed surfaces.
- Disinfect/wipe clean (spray/wipe) technique should be consistently used to disinfect surfaces.
- Instruments must remain bagged until needed for patient treatment.
- Gloves and facemasks should be worn by the dentist and any auxiliary providing or assisting with treatment.
- Gloves and masks, per CDC Guidelines, should be worn by the dentist and any auxiliary providing or assisting with treatment.
- Gloves and masks should be changed between patients.
- Treatment staff should scrub with antibacterial soap before and after all intra-oral procedures.
- The dental laboratory area should be separate from the sterilization area or evidence of no cross contamination.
- Impressions are disinfected prior to sending to lab.
QUALITY ASSURANCE

Medical Emergencies
Objective: The office staff should have the ability to respond to medical emergencies in a timely manner.

Criteria:
- Office has emergency portable oxygen with positive pressure and mask or an ambubag.
- During regular office hours, the dentist and at least one staff member should have current CPR certification that meets state guidelines.
- A Medical Emergency Plan should be in place and known by all staff members.
- Office has emergency protocols and emergency numbers are posted by the telephone or programmed into the telephone (clearly identified).

Environmental and Radiology Safety
Objective: Environmental and radiation safety standards should be followed.

Criteria:
- Treatment staff must be vaccinated against Hepatitis B or have a signed refusal on record.
- Sharps should be properly disposed of in appropriately bio-hazard marked puncture-resistant containers.
- Bio-hazardous waste and sharps containers are present with evidence of proper disposal.
- An appropriate carrier should be utilized to eliminate infectious waste.
- Radiation sources should meet current standards and be in good working order. Leaded aprons/shields should be used on all patients (cervical collar suggested).

Initial or routine appointments should be routinely available within four weeks and hygiene appointments within six weeks.
- 24-hour emergency access should be available.
- Office should be compliant with the plan’s Language Assistance Program.
- Utilization of qualified interpreter services, when necessary, (e.g., when the patient requests such services or does not desire utilizing their own interpreter).

Note: qualified interpreter services may include dental office staff who have demonstrated proficiency in the language(s) necessary.

The Patient Record
Individual records should be used for each patient. All records should be written in ink without erasure or white out. Records should be kept in compliance with state and federal laws on confidentiality.

Registration
Objective: All patient records should contain pertinent registration information.

Criteria:
- All records should contain an identification form that includes the following items:
  » Name
  » Address
  » Date of birth
  » Sex

Patient Care Services
Objective: There should be written protocols or policies to guide the dental office staff in the procedures for providing dental care to patients.

Criteria:
- An organized recall system should be utilized.
QUALITY ASSURANCE

» Telephone number (work and home)
» Social Security Number
» Signature of patient certifying accuracy of registration information
» Contact person in case of emergency

Health History
Objective: All records should contain a health history to record and observe pertinent information necessary to arrive at a comprehensive diagnosis and treatment plan. The type of information collected for an adequate examination depends on whether the patient is seeking comprehensive care or is in need of emergency care.

Criteria:
- A comprehensive health history should be utilized and must include questions regarding latex allergy and history of Phen-Fen usage.
- The health history should contain documentation that follows the American Medical Association precautions related to documented medical problems (e.g., mitrovalve prolapse).
- The health history questionnaire should require yes/no responses.
- The initial health history should be signed and dated by the patient/parent/guardian.
- The initial health history should be signed and dated by the dentist.
- The health history should be updated with the patient/parent/guardian signature and date at reasonable intervals (e.g., 6 month recalls).
- The health history should be updated with the dentist’s signature and date.
- Patients with medical conditions significant to dental treatment should have a medical alert noted on the outside of the record (specific conditions should be noted within the record).
- Health history includes allergies and sensitivities to drugs, including anesthetics.
- Health history assesses specific classes of clinical disorders (e.g. bleeding, nervous, autoimmune, artificial prosthesis)

Dental History
Objective: All records should contain a dental history to record and observe all pertinent information necessary to arrive at a rational diagnosis and treatment plan. The type of information collected for an adequate history and examination depends on whether or not the patient is seeking comprehensive care or is in need of emergency care.

Criteria:
- Patient record should contain comprehensive dental history and the chief complaint.

Soft Tissue Examination
Objective: All records should contain documentation of the soft tissue examination, where necessary and appropriate.

Criteria:
- The patient record should contain documentation of a comprehensive soft tissue evaluation, including oral cancer screening of the following:
  » Lips
  » Tongue
  » Floor of mouth
  » Frena
  » Mucosa
  » Palate
  » Oropharynx
  » Salivary glands

Dental Charting
Objective: All records should contain an evaluation of the patient’s dentition, where necessary and appropriate.

Criteria:
- The patient record should include documentation of findings, which are evident clinically and/or radiographically.
- The dental charting should provide adequate documentation of patient’s dentition, including missing teeth, teeth requiring treatment and any anomalies.
QUALITY ASSURANCE

Preventive Care

Objective: All patient care services provided should meet the standards as established by the ADA or local standards of care.

Criteria:
- Previous and current status of the patient’s oral health should be documented.
- Oral hygiene practices should be reviewed and necessary instruction provided and documented.
- A systematic record and notification procedure for the recall of patients should be maintained and documented.
- Home care instructions should be documented.

Periodontal Evaluation

Objective: All records should contain an evaluation of the patient’s periodontium. At a minimum a PSR test or its equivalent should be documented, where necessary and appropriate.

Criteria:
- The patient record should include documentation of a periodontal screening evaluation.
- A complete periodontal evaluation and diagnosis should be documented and charted for patients with significant periodontal problems.
- Reevaluation of periodontal status should be documented with each recall examination.

X-Rays

Objective: X-rays are an important part of the patient record. They should not pose any undue hazards to patients or staff and should contribute to the ongoing diagnostic evaluation of the dentition and other oral structures. Guidelines published by the Academy of General Dentistry (AGD) for prescribing dental X-rays should be considered.

Criteria:
- All X-rays should be of acceptable diagnostic quality and quantity.
- X-rays should be filed with the patient’s record for reference in subsequent evaluation and treatment.
- The number of radiographic exposures for each patient should be the minimum number needed in accordance with the guidelines established by the Academy of General Dentistry.
- Duplicate films should be transferred upon request and/or forwarded with patient referral to other practitioners to prevent or minimize need for exposure to radiation.
- All full-mouth, panoramic, periapical and bitewing X-rays should be of diagnostic value and properly mounted, dated and identified.
- Patient refusal of X-rays should be documented in the record each time X-rays are refused.

Treatment Plan

Objective: All records should contain a statement of the services to be performed for the patient based upon a review of the history, clinical examination and diagnosis to arrive at a logical plan to eliminate or alleviate the patient’s dental symptoms, problems and diseases and to prevent future degenerative changes.

Criteria:
- The treatment plan should be documented.
- Identification of urgent care needs.
- Acceptance/changes/declines signed by patient/parent/guardian.

Progress Notes

Objective: All records should contain accurate and well-organized progress notes that describe and document all of the treatment and services rendered. Accurate and well-organized progress notes should enable the reader to reconstruct the care of the patient with minimal assumptions.
QUALITY ASSURANCE

Criteria:
- Progress notes for the initial and routine care entry should include the following:
  » Legible entries
  » The date of services rendered
  » Documentation of exam findings
  » Tooth numbers and quadrants
  » Description of comments and services rendered
  » Documentation of the type of material used
  » Documented prescribed medications
  » Signature, initials or provider code of provider(s) rendering care
  » Anesthesia or analgesia type and amount are documented
  » Post-op general instruction and/or follow-up protocols are documented in the record
  » Documentation of lab information is appropriate (e.g. prosthetics, pathology)
  » There is evidence of regular/timely recall appointments
  » Records of informed consent are present in the patient record, dated and signed by provider and patient/parent/guardian
  » There is evidence of documentation of acceptance or rejection of qualified interpreter services, as applicable

Informed Consent
Objective: Informed consent is an acknowledgement on the part of the patient. Therefore, the patient record should contain evidence that informed consent occurred and was signed by the patient/parent/guardian.

Referrals
Objective: Applicable records should contain the appropriate referral form detailing treatment recommended.

Criteria:
- The Referral form should detail the patient’s condition that necessitated the referral.
- The specialist’s treatment plan, progress reports and all similar, related documents should be kept within the patient record.
- A method for follow-up for referrals should be in place.

Review
Objective: All dental offices have a commitment to maintain high standards of dental care. To demonstrate that these standards are being met, an organized quality improvement program has been established.

Review Criteria
- A pre-participation review of the dental practice will be conducted.
- Regular reviews of each participating office will be conducted, as frequently as necessary to verify adherence to federal and state regulation and quality standards.
- Documentation of deficiencies and appropriate follow up will be provided to the dental office.

Categories to be Evaluated
- Legal consideration--license, etc.
- Staffing and efficiency
- Availability (office hours and emergency care)
- Facility and equipment
- Patient records (X-rays)
- Patient satisfaction
- Location and accessibility

Review Process
The review process for Dental Offices will involve two categories: a pre-participation evaluation and the ongoing quality assessment audit of dental offices.
QUALITY ASSURANCE

participating in the Primary Dental Office and Specialty Care Network.

The pre-participation review process will be the responsibility of a United Concordia Representative who will evaluate an office based on the standards of participation. The review will consist of the following:

- Assessment of office location, as it relates to current and projected enrollment and other Network Offices.
- Review of utilization and practice patterns, if applicable.
- Review of the completed Site Application and individual Credentialing Application.
- Standards for participation will be used to determine the inclusion of a dental office in the Network.
- Evaluation forms will be standardized to provide for a consistent review mechanism.
- Participation is based upon the decision of the Credentialing Committee.

The ongoing quality assessment process for participating dental offices will include:

- Periodic Review
- Review of patient records
- Site assessment
- Subscriber surveys to determine patient satisfaction, when appropriate
- Documented feedback to the practice

Utilization Review

- Review of reported services
- Analysis of the number and types of services provided
- Analysis of specialty referrals

Focus Review

- Unsatisfactory periodic review, where full approval is not given
- A trend of over/under treatment of dental procedures
- A trend of complaints/grievances

Member Complaint/Grievance Procedures

United Concordia participating dentists should understand that an important component of our ongoing quality analysis is our member complaint/grievance procedure. A complaint/grievance is defined as an expression of dissatisfaction of quality of care and/or service concerns made by the member or the person acting on the member’s behalf.

Statement of Intent

United Concordia is dedicated to providing high-quality, personalized, comprehensive dental benefits to all members in a manner that strengthens the provider patient relationship. United Concordia recognizes the need to have complaint/grievance procedures to ensure timely, responsive and fair resolution of those member problems which cannot be resolved through more informal means. The objectives of the complaint/grievance procedures are as follows:

- To provide a consistent approach to recording and resolving member complaints/grievances.
- To provide a mechanism to assure that the appropriate decision maker reviews the complaint/grievance.
- To ensure that the complaint/grievance has been resolved appropriately.
- To ensure that the necessary follow-up and communication have been executed once the outcome of the complaint/grievance has been determined.
- To review and track results as part of the recredentialing process.

Filing a Complaint/Grievance

Any United Concordia member not satisfied with any quality aspect of their care provided by a participating dentist may file a written complaint/grievance. The member or a person acting on the member’s behalf must file a complaint/grievance within 180 days of a problem. The complaint/grievance should contain sufficient detail to identify the nature of the problem.
QUALITY ASSURANCE

No member who exercises the right to file a complaint or a grievance will be subject to disenrollment or otherwise penalized due to the filing of a complaint or grievance.

Complaint/Grievance Process

- Member complaints/grievances raising quality of care and service issues are submitted to the Grievance staff of the Professional Affairs Division of United Concordia. Members or persons acting on the member’s behalf may submit any documentation to support their complaint/grievance, which they believe is relevant.
- The complaint/grievance will be referred initially to a dental professional, who will open a case file and conduct an investigation. In resolving complaints/grievances, best efforts are made to obtain all relevant information, including clinical records.
- If appropriate, provider(s) in question will be contacted and given the opportunity to respond to the complaint/grievance. The provider(s) may be requested to submit copies of the patient’s clinical records, including radiographs and billing ledgers.
- All materials submitted will be referred to an appropriately licensed Dental Director or other dental professional for review.
- The Dental Director or other designated dental professional will render a decision that is forwarded in writing to all parties within 60 days of receipt of the complaint/grievance.
- The dental professional records and tracks the results of the review.

If a member requests a copy of his/her clinical dental records from United Concordia, the member will be directed to the dentist(s), who is/are the custodian(s) of those records. However in some circumstances (including, but not limited to specific state or federal requirements), the member may be provided (upon written request), reasonable access to and copies of all documents, records and other information relevant to or considered in making the determination. United Concordia Legal Counsel will be consulted before any such information is released to the member.

Member Transfer Policy

Primary Dental Office Initiated
The Primary Dental Office may request that a member be transferred out of their office. This request must be submitted in writing and include a valid reason for transfer. You may fax the request to Customer Service at (570) 321-5199.

If approved, United Concordia will notify the member in writing of the request to transfer and ask the member to select an alternative office. If the member does not select an alternative office within 30 days, United Concordia will make the new office selection.

In the interim, the current dental office is responsible for all palliative treatment.

Member Initiated
A member requesting a dental office transfer should be referred to the Customer Service Department at (866) 357-3304.

Disciplinary Procedures

United Concordia's focus is to gather data to establish realistic baselines and identify chronic quality of care deficiencies. If deficiencies are identified through quality assessments, recredentialing, utilization review or member quality of care and service complaints/grievances, a narrative report and cover letter are sent to the office identifying areas requiring corrective action. After evaluation, the Credentialing Committee handles remedial actions on a case-by-case basis. Disciplinary action is implemented, as needed, to ensure adequate care is rendered to United Concordia members.

At times, it may be necessary to place a network dental office on probation. Probation violations may include:
- Repeated, inappropriate charges
- Major inadequacies in the patient record
- Quality and control of dental services performed
- Repeated member complaints/grievances
- Refusal to comply with the network quality standards
QUALITY ASSURANCE

The procedure for putting an office on probation is as follows:

• Notification of the probation is sent, advising that compliance is expected within an allotted timeframe.
• The office may be closed to new enrollment.
• If it is determined that the office has complied and corrected the inappropriate activities, the office will be reopened to new enrollment and the probation removed.
• If there is non-compliance, the Credentialing Committee will review the case and make recommendations.
• If the Credentialing Committee determines that the office should be terminated, a letter will be sent advising the office of the action to be taken.

The aforementioned components and any previous aberrant findings are then submitted to the Credentialing Committee for consideration and decision for continued participation. The Committee’s decision, a narrative report and cover letter are sent to the office identifying areas requiring corrective action prior to the next on-site audit. If the Committee determines that an office is to be terminated, the office is afforded the opportunity to appeal; however, enrollment is closed pending the results of the appeal process.

All appeals must be made in writing within 30 days of United Concordia’s notification of termination. Any written appeals will be referred to United Concordia’s Quality Management Committee (QMC) for consideration. The Credentialing Committee’s decision will be stayed pending the outcome of the appeal process. However, new patient enrollment shall remain closed pending the results of the appeal process. Termination decisions of the QMC can be appealed to the Dental Review Panel.

Serious quality deficiencies resulting in termination may be reported to the State Dental Board and/or the National Practitioner Data Bank (NPDB), if deemed appropriate by the Committee terminating the office.

24 Hour Emergency Coverage

Policy
The Primary Dental Office is required to maintain specified appointment availability standards, including after-hours availability 24 hours a day, seven days a week. Appointment availability for after-hours access is monitored and evaluated during the routine onsite facility review conducted by the plan. This monitoring includes evaluation of the specific mechanism(s) used for after-hours availability.

Purpose
After hours availability of the Primary Dental Office is important to provide access to care, during times other than normal dental office hours. This availability allows patients to receive care or appropriate attention for emergency dental conditions.

Procedure
Acceptable methods of after-hours coverage include and are not limited to:

• A live answering service that will forward emergency patient’s telephone call to the doctor on call.
• An automatic telephone answering system that includes instructions on how to contact the doctor on call. These instructions must include a home telephone number, cell phone number or pager number.
• A forwarding system by which a patient’s telephone call will be automatically forwarded to the doctor’s home telephone, cell phone or pager.

Unacceptable methods of after-hours coverage include, but are not necessarily limited to:

• No telephone answering system or service.
• An automatic telephone answering system that does not include a method of direct access to the doctor on call.
QUALITY ASSURANCE

After Hours Office Access Policies & Procedures

Policy
The Primary Dental Office is required to maintain specified appointment availability standards, including after-hours availability 24 hours a day, seven days a week. Appointment availability for after-hours access is monitored and evaluated during the routine onsite facility review conducted by United Concordia. This monitoring includes evaluation of the specific mechanism(s) used for after-hours availability.

Purpose
After hours availability of the Primary Dental Office is important to provide access to care during times other than normal dental office hours. This availability allows patients to receive care or appropriate attention for emergency dental conditions.

Procedure
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• An automatic telephone answering system that includes instructions on how to contact the doctor on call (these instructions must include a home telephone number, cell phone number or pager number).

• A forwarding system by which a patient’s telephone call will be automatically forwarded to the doctor’s home telephone, cell phone or pager.

Unacceptable methods of after-hours coverage include, but are not necessarily limited to:

• No telephone answering system or service.

• An automatic telephone answering system that does not include a method of direct access to the doctor on call.

Directories
Members with a foreign language preference will be able to select a participating office fluent in their language of choice because both our paper and online directories indicate the foreign languages fluently spoken by participating offices.
AUTOMATED SERVICES
My Patients’ Benefits

United Concordia provides direct, up-to-the-minute access to member information via the Web. Access our Web site at www.unitedconcordia.com to register for My Patients’ Benefits and have online access to the following information 24 hours a day, 7 days a week:

- **Eligibility:** Provides membership information including effective dates, types of plans, cancellation dates and will verify if your office has been selected by the patient as their Primary Dental Office
- **Benefits:** Gives detailed information on a patient's benefits and limitations
- **Claim Status:** Determines if a claim is still in process or has been adjudicated. If the claim has been adjudicated, the check number, amount, date, and payee will be displayed. You can determine what maximums, deductibles, or coinsurances have been applied. If a claim is rejected, a rejection description will tell you the reason.
- **Maximum/Deductible:** Gives maximum and deductible calculations and thresholds applicable to the patient
- **Procedure History:** Lets you determine specific services that are on record at United Concordia for a particular patient and the dates they were last provided
- **Allowance Information:** Provides allowance information for the networks with which the office is associated, and also offers the option to download the complete Maximum Allowable Charge (MAC) schedule.
- **Procedure Code Information:** Gives instant access to procedure code descriptions, valid place of service, tooth related information, X-ray requirements, and appropriate benefit categories for coverage.
- **Orthodontic Information:** Gives detailed information on a patient's active orthodontic treatment plan and a printer-friendly version is also available.

**Interactive Voice Response (IVR) System**

United Concordia's Dental Customer Service IVR System offers dentists and most subscribers access to information stored in United Concordia's records via the telephone. You may choose to listen to the information or request the information by fax or mail.

The IVR System connects you directly to our databases and gives you the ability to receive:

- Patient eligibility and benefits
- Orthodontic information
- Maximum/deductible accumulations
- Fee schedules
- Claim/predetermination status information
- Procedure history
- DHMO co-payment schedules
- Procedure allowances

The IVR System is accessible through United Concordia's toll-free Customer Service number at (866) 357-3304. The IVR system is available 24 hours a day, 7 days a week, except when our databases are undergoing scheduled maintenance.

**Speed eClaim®**

Participating and non-participating dentists can submit claims electronically for free to United Concordia using Speed eClaim®. If you have Internet access and version 6.0 or greater Web browser, you can use Speed eClaim® to submit claims directly to United Concordia for free and paperless processing! This real time processing feature provides you with immediate processing results. You can also run daily reports summarizing your practice's activities, including the number of claims submitted, finalized and/or pending.
You can obtain immediate access to Speed eClaim® by registering on our Web site at www.unitedconcordia.com.

**DHMO Eligibility/Capitation Reports**

United Concordia offers instant, secure access to DHMO Eligibility/Capitation Reports for DHMO Primary Offices. Reports for the past three months are available in a printer-friendly format, allowing your office to view or print all your Eligibility/Capitation reports online. You can obtain immediate access to these reports by registering on our Web site at www.unitedconcordia.com.

**Provider Check Information**

Dental offices are able to view check summaries, check detail and check related claims for a selected date range using this secure online tool.

**Electronic Data Interchange (EDI)**

In addition to Speed eClaim®, electronic claims can be submitted to United Concordia through a clearinghouse or vendor that collects the claims from your office and forwards them to United Concordia. Also, electronic claims can be submitted directly to us if your practice management software allows for a direct connection to United Concordia.

For more information on direct electronic claims submission or to receive a listing of those software vendors, billing services and clearinghouses that are currently in production with United Concordia, please visit www.unitedconcordia.com.

**Benefits of Submitting Claims Electronically**

There are a number of significant benefits to submitting claims electronically:

- **Elimination of paperwork and postage costs:** By submitting claims electronically, you can eliminate the staff time and postage cost required to prepare and mail paper claims.
- **Accuracy:** Because electronic claims are entered directly into United Concordia's automated claims processing system, your claims process more quickly and the chance of processing errors is significantly reduced.

  - **Flexibility:** You control the frequency and volume of submission.
  - **Dedicated support personnel:** United Concordia has a department dedicated to supporting electronic claim billers known as Dental Electronic Services (DES), which provides information about electronic services available with United Concordia, assist throughout the testing process and supply ongoing support during the production phase.
  - **Security:** Your computer files remain secure and confidential. The only data we can read are the claims that you send to us. You initiate the request to send us files. We can never call your computer or read the data in it.
  - **Electronic Reports:** For a detailed explanation of United Concordia’s reports, please refer to the page 67.

DES has established agreements with the following clearinghouses or vendors to reduce costs for electronic claim submission for you:

**Affiliated Network Services (ANS):**
(312) 236-6616

**BRS Computing LLC:**
(914) 747-0201

**EDI Health Group, Inc:**
(800) 576-6412

**Electronic Dental Services:**
(651) 480-8090

**Emdeon Dental Services:**
(888) 416-0673

**Lindsay Technical Consultants:**
(507) 947-3070

**Mercury Data Services:**
(866) 633-1095

**PracticeWorks, Inc., a subsidiary of Eastman Kodak Company:**
(800) 262-8593
How to Become Eligible to Submit Electronic Claims

Effective May 23, 2007, use of the National Provider Identifier (NPI) became a government mandated requirement for electronic health care transactions. In addition, individual states may require use of the NPI for paper claims. To minimize potential claim processing errors and delays in payment, United Concordia encourages all dentists to obtain NPIs. There are three basic types of NPI’s available:

• Individual
• Organizational
• Subparts

The Individual (entity type 1) includes sole proprietors, providing health care services. An application for an Entity Type 1 NPI is completed using the individual dentists’ social security number. Only one NPI will be allowed for an individual dentist.

Organizations (entity type 2) include group practices, professional corporations, clinics and incorporated individuals. Application for an Entity Type 2 NPI is completed using the organization’s Employer Identification Number. A dental practice that is incorporated is considered an Entity Type 2, even if it employs only one dentist.

Subpart NPI’s are given to components of organizations, such as affiliated sites that operate independently from the “parent organization,” conducts their own HIPAA standard transactions, certified by the State separately from the “parent” organization and must be uniquely identified in HIPAA standard transactions.

Here are three simple and free ways to apply for your NPI:

• Follow the online process at: www.nppes.cms.hhs.gov.
• Contact the NPI enumerator at (800) 465-3203 or customerservice@npienumerator.com.

As soon as you receive your NPI, submit it along with your entity type (1 or 2), National Plan and Provider Enumeration System (NPPES) confirmation, address and your United Concordia provider number using one of the following methods:

Fax: (866) 223-2770
Mail to: United Concordia Companies, Inc.
Attn: Provider Data Management
PO Box 69415
Harrisburg, PA 17106-9415

Submitting Claims Requiring Attachments

United Concordia developed a hassle-free process for submitting electronic claims and attachments. This process saves dental offices time and eliminates the need for duplicating and mailing X-rays.

United Concordia works with National Electronic Attachment, Inc. (NEA) to receive dental attachments electronically, via FastAttach™. This system enables approved electronic dental offices to transmit attachments (e.g., X-rays, periodontal charts, intra-oral pictures, narratives and Explanation of Benefits (EOBs) to NEA’s repository using the Internet.

United Concordia is able to access the repository and view the attachments required to adjudicate the electronically submitted claims. Please visit NEA’s Web site www.nea-fast.com for additional information or call National Electronic Attachment, Inc. at (800) 782-5150.
United Concordia also works with Renaissance Systems and Services, LLC, a software vendor, to receive electronic attachments. Renaissance Systems and Services, LLC has included the electronic attachment feature as part of their Practice Management system. This update allows dental offices to send electronic attachments (periodontal charts, X-rays or any other images) with electronic claims. Dentists can access the Web site www.rss-llc.com for additional information or call Renaissance Systems and Services, LLC at (866) 712-9584.

Any questions concerning electronic claims submission may be directed to the United Concordia Dental Electronic Services department at (800) 633-5430, Monday through Friday from 8:00 a.m. to 5:00 p.m. EST.

**Important Rules and Regulations of the Standards for Electronic Transactions**

When conducting an electronic transaction covered under the Standards for Electronic Transactions, a covered entity must report standard dental codes that are valid at the time the health care is provided. According to the 837 Dental Electronic Claim Guide, only CDT (Current Dental Terminology) codes can be submitted on this transaction. CPT and HCPC codes that can be covered under dental benefits cannot be submitted on the 837 Dental Electronic Claim Transaction but can be submitted on the 837 Professional Electronic Claim Transaction. Please note that National Modifiers cannot be submitted on the 837 Dental Claim Transaction, as the American Dental Association (ADA) does not currently recognize the use of modifiers with their CDT codes. However, National modifiers can be submitted on the 837 Professional Claim Transaction.

The HIPAA regulations do require a health care provider who uses electronic media to transmit health information in connection with one of the HIPAA transactions to do so in compliance with the regulations. United Concordia can accept and transmit the following HIPAA-compliant transactions:

- **Accepted Transactions:**
  - 270-Health Care Eligibility Inquiry
  - 276-Health Care Claim Status Requested
  - 837-Health Care Claim (Dental and Professional)

- **Transmitted Transactions:**
  - 271-Health Care Eligibility Benefit Response
  - 277-Health Care Claim Status Response
  - 835-Health Care Claim Payment / Advice

**Reports**

With Speed eClaim®, you will receive a daily report that summarizes your submissions. If you send your electronic claims directly to United Concordia, you will receive a 997 Functional Acknowledgement Report and a 277 CA Report. If you utilize a clearinghouse or vendor, these reports are sent to the clearinghouse or vendor, who is then responsible for passing the report information back to your office. Below is a list of the reports and a brief explanation of their purpose.

- **997 Functional Acknowledgement Report**
  If you bill directly to us, after you transmit a file of claims, you will receive a 997 Functional Acknowledgement Report, which will confirm receipt of your claims. If you use a clearinghouse or vendor, they receive the 997 Functional Acknowledgement Report from us.

- **277 CA Claims Acknowledgement Report**
  Within 24 hours after your claims are submitted and accepted through the 997 Functional Acknowledgement Report process, they are subject to a set of edits in our computer system to make sure that all the information is reported correctly. The results of this edit check are outlined on the 277 Claims Acknowledgement Report, which indicates whether all, none or some of the claims were accepted. If the entire file or some of the claims are rejected, you must correct the errors identified and resubmit the file or corrected claims for processing.

  If you bill directly to us, it is necessary that you retrieve this report. If you use a clearinghouse or vendor, it is their responsibility to retrieve this report and pass it on to you.
835 Healthcare Claim Payment/Advice Report
United Concordia provides a weekly 835 Healthcare Claim Payment/Advice Report to assist in your accounts receivable process. Please contact Dental Electronic Services for more information on receiving this report. Some of the information contained in this report includes:

- Provider number of the dentist or group receiving payment
- Patient’s name, patient control number, service rendered, date of service and billed charge
- Allowed amount for the service
- Actual payment made for the service
- Amount applied to the patient’s deductible, if applicable
- Check number and issue date
- Reason for rejection of denied service

Dental Electronic Services is working closely with all dentists, vendors and clearinghouses that receive or transmit electronic transactions. If you wish to obtain information on submitting electronic transactions, visit our Web site at www.unitedconcordia.com.
Commonly Used Forms
Outlined below is a list of the most commonly used forms that will be utilized by your office.

**Broken Appointment Letter**
To be used by offices who wish to inform a patient of the broken appointment policy.

**Credentialing Application (District of Columbia & Virginia)**
To be completed for each associate (general dentist or specialist) of a District of Columbia or Virginia practice. Include required fields of Social security number, date of birth, signature and date, a copy of current malpractice insurance, copy of pocket dental license, copy of DEA Certificate and copy of Specialty Certificate (if applicable), are also required.

**Credentialing Application (Maryland)**
To be completed for each associate (general dentist or specialist) of a Maryland practice. Include required fields of Social security number, date of birth, signature and date, a copy of current malpractice insurance, copy of pocket dental license, copy of DEA Certificate and copy of Specialty Certificate (if applicable), are also required.

**Primary Dental Office Agreement (District of Columbia & Maryland)**
A signed agreement is required for each practicing general dentist at a participating location, if your office is sold to a new owner or if you are opening a new office.

**Primary Dental Office Agreement (Virginia)**
A signed agreement is required for each practicing general dentist at a participating location, if your office is sold to a new owner or if you are opening a new office.

**Specialty Care Dental Agreement (District of Columbia & Maryland)**
A signed agreement is required for each practicing general dentist at a participating location, if your office is sold to a new owner or if you are opening a new office.

**Specialty Care Dental Agreement (Virginia)**
A signed agreement is required for each practicing general dentist at a participating location, if your office is sold to a new owner or if you are opening a new office.

**Practice Application**
To be completed if your office moves or is adding an additional office.

**Specialty Care Referral/Claim Form (District of Columbia & Virginia)**
To be used for specialty care referrals in District of Columbia and Virginia.

**Uniform Dental Consultation Referral Form (Maryland)**
To be used for specialty care referrals in Maryland.

**Claim Form**
A United Concordia (or ADA) Claim Form should be submitted for all completed procedures.
Date ________________________________

Dear ________________________________:

The time the doctor sets aside for a patient is valuable. The dental appointment reserved for your care places responsibility on the doctor and the patient. In order to have quality dental care at an affordable cost, these appointments must be kept.

The appointment reserved for ______________________ on __________________for _________ minutes was not kept. Therefore, in accordance with the agreement between your group and United Concordia Companies, Inc. (UCCI), there is a charge for each fifteen (15) minute block of time reserved.

Payment of _________________ should be made directly to this office. If you have any questions, please contact this office.

Yours for Good Health,

Office Manager
Credentialing Application

This form should be typed or legibly printed in black or blue ink. Please answer all questions completely and fully. If more space is needed than provided on this application, attach additional sheets and reference the question being answered. If a question is not applicable to you, please respond with N/A.

Incomplete applications cannot be processed and this will delay the credentialing processing.

SECTION I – Personal Information

Last Name: ____________________________ First Name: ___________ MI: _______ Suffix: ____________

Previous Name Used (if applicable): __________________________________________

Professional Degree (DDS, DMD, etc.): _____________________ Date of Birth: ___________ Male ( ) Female ( )

SS # (required for identification and verification purposes): _______________________

Languages Spoken: __________________________________________________________

If you are not a US Citizen, do you have authorization to work in the US? Yes ( ) No ( ) N/A ( )

SECTION II – Current Practice Information

On a separate sheet of paper, list any additional dental facilities where you currently practice, beginning with the most recent.

Practice Name: ____________________________

Office Phone: ____________________________ Fax: ____________________________

Email: ________________________________

Street Address: ____________________________ City/ST/Zip: ____________________________ County: ____________________________

Office accessible by public transportation: Yes ( ) No ( ) Treat disabled adults: Yes ( ) No ( )

Handicapped parking: Yes ( ) No ( ) Treat disabled children: Yes ( ) No ( )

Off street parking: Yes ( ) No ( )

Federal TIN/EIN #: ____________________________ TIN/EIN Name: ____________________________

National Provider Identifier (NPI) – include a copy of your National Plan and Provider Enumeration System (NPPES) confirmation(s): NPI Entity Type 1: ____________________________ NPI Entity Type 2: ____________________________

Which # is to be used for your Federal 1099 Tax Requirements (please circle)? TIN/EIN # SS#

Will you accept new patients from our HMO plans? Yes ( ) No ( )

Will you accept new patients from our PPO plans? Yes ( ) No ( )
SECTION III – License Information

Be sure to attach current copies of all license(s).

License #: ___________________ State Issued: ___________ Expiration Date: ___________
License #: ___________________ State Issued: ___________ Expiration Date: ___________
License #: ___________________ State Issued: ___________ Expiration Date: ___________
State Drug Registration # (if applicable): ___________________ Expiration Date: ___________
DEA Certificate License # (if applicable): ___________________ Expiration Date: ___________
Anesthesia/Analgesia License # (if applicable): ________________ Expiration Date: ___________
Indicate Anesthesia Type(s):

- Conscious Sedation (   )
- Enternal Sedation (   )
- General Anesthesia (   )
- Nitrous Oxide (   )

SECTION IV – Liability Insurance

Attach a copy of your current malpractice coversheet. The following items MUST be reflected on the coversheet: applicants name, policy #, coverage limits and policy period.

Malpractice Carrier: ___________________ Exp. Date: ________________
Coverage Amounts (Per Occurrence/Aggregate): ____________________ / ____________________

SECTION V – Education

Please do not abbreviate school name.

Dental School: ___________________ Graduation Date: ___________
Residency Information (if applicable):

Facility: ___________________ Completion Date: ___________
City/ST/Zip: ___________________

Specialty: General Dentist (   ) Endodontist (   ) Oral/Maxillofacial Surgeon (   ) Orthodontist (   )
Pediatric Dentist (   ) Periodontist (   ) Prosthodontist (   )

Specialty Board Status (American Board Only):

- Board Certified (   )
- Board Eligible (   )
- Not Board Eligible (   )

SECTION VI – Work/Practice History

List any private practice affiliations or other employment since completion of dental school and current practice location. For any time period of more than 6 months not covered by any affiliation or training, please provide a written explanation.

Practice Name: ___________________ Street: ________________ City/ST/Zip: ________________

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Rev 11/09/06                                      Page 2 of 4
SECTION VII – Hospital Affiliation

Hospital Name: ___________________________ Address: ___________________________ Start/Expire Dates: ___________________________

Privileges: Courtesy ( ) Active ( )

SECTION VIII – Attestation Questions

Any YES attestation answers require that a complete explanation be attached to this application. Please be sure to include the dates, amounts, outcome and signature of the applicant.

1. Do you have any pending malpractice (or civil) claims against you? Yes ( ) No ( )
2. Are you currently aware of any malpractice (or civil) situation that could lead to a malpractice suit against you? Yes ( ) No ( )
3. Has any malpractice carrier made an out of court settlement or paid a Professional Liability claim on your behalf in the past five years? Yes ( ) No ( )
4. Has your Professional Liability Insurance ever been denied, suspended, revoked, canceled or not renewed in the past five years? Yes ( ) No ( )
5. Have you ever had a change of status in your Dental License(s), Hospital Privileges, Board Certification or Narcotics License(s)? Yes ( ) No ( )
6. Has a governmental agency, including a state licensing board, investigated you, suspended, revoked or taken any other action against either your Narcotic(s) Licenses or License(s) to practice dentistry? Yes ( ) No ( )
7. Have any Medicare/Medicaid charges been filed against you, or has your participation in any government programs ever been denied, suspended or revoked? Yes ( ) No ( )
8. Have you been indicted for, convicted of, or pleaded “no contender” to a felony, moral or ethical crime? Yes ( ) No ( )
9. Have you ever been convicted for use, possession or sale of illegal drugs? Yes ( ) No ( )
10. Do you currently, or did you in the past two years, engage in the unlawful use of drugs, including improper use of prescription drugs? Yes ( ) No ( )
11. Do you have any limitations for which reasonable accommodation is necessary in order to perform the essential and/or marginal duties of your job? Yes ( ) No ( )
12. Have you ever been denied admission to or removed from any other health program? Yes ( ) No ( )
13. Are you employed by the United States Government? Yes ( ) No ( )
SECTION IX – Attestation Release
I acknowledge and agree that United Concordia Companies, Inc. has a valid interest in obtaining and verifying information concerning my professional competence in determining whether to enter into an agreement with me for the provision of dental services to members of the affiliated prepaid dental care plans. Accordingly,

(i) I attest to United Concordia Companies, Inc. that the information obtained in the attached application is true and complete to the best of my knowledge. I agree to inform United Concordia Companies, Inc. promptly if any material change in such information occurs, whether before or after my entering into an agreement with United Concordia Companies, Inc. for the provision of dental services.

(ii) I hereby consent to the release to United Concordia Companies, Inc., of any information which may reasonably be considered relevant to an evaluation of my professional competency, including any information relating to any disciplinary action, suspension, or curtailment of dental privileges, and also including such elements of my character, morals, and ethics which may reasonably be considered to have an impact upon my professional competency and reputation, by any hospital, professional society, licensing authority, health maintenance organization, dental plan organization, health insurer, malpractice insurer, attorney, data bank, or any other person or entity which may possess such information.

(iii) I authorize United Concordia Companies, Inc. and their affiliates, subsidiaries, or related entities to consult with hospital administrators, the State board, malpractice carriers, and other persons to obtain and verify information. I release United Concordia Companies, Inc. and their employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluation my application.

(iv) I release from liability any and all individuals and organizations, including, but not limited to hospitals, medical staff offices, professional societies, licensing authorities, and health and dental maintenance organizations, who provide information to the credential verification organization, in good faith and without malice, information concerning my professional competence, ethics, character and other qualification for professional service.

Print Full Name

Date

Signature (Stamps not Accepted)

Attention Credentialing Department
United Concordia Companies, Inc.
4401 Deer Path Road
Harrisburg, PA 17110

United Concordia Companies, Inc. will not deny an application for participation or terminate participation in its provider network on the basis of gender, race, religion, age or national origin.
### SECTION 1  Personal Information and Professional IDs

**Provider Type**

This form may be completed and sent electronically or in printed form. Tips to avoid processing delays:

1. Complete only this application and its supplemental forms. Do not use another application or credentialing form.
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Enter information legibly and inside the boxes and spaces provided.
4. Complete all sections that are applicable to you. Use supplemental forms where appropriate.
5. Some fields use “codes” to help you easily report information (e.g., schools, languages). Code lists are found on pages 24-26.
6. Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

**Name**

Do not use nicknames or initials, unless they are part of your legal name.

<table>
<thead>
<tr>
<th>LAST NAME*</th>
<th>SUFFIX (JR, III)</th>
</tr>
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<tbody>
<tr>
<td>FIRST NAME*</td>
<td>MIDDLE NAME</td>
</tr>
</tbody>
</table>

**HAVE YOU EVER USED ANOTHER NAME?**

YES NO

IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

<table>
<thead>
<tr>
<th>OTHER LAST NAME</th>
<th>SUFFIX (JR, III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTHER FIRST NAME</td>
<td>OTHER MIDDLE NAME</td>
</tr>
</tbody>
</table>

**DATE STARTED USING OTHER NAME (MM/DD/YYYY) **

**DATE STOPPED USING OTHER NAME (MM/DD/YYYY)**

**General Information**

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

**GENDER**

MALE FEMALE

**DATE OF BIRTH**

**CITY OF BIRTH**

**STATE OF BIRTH**

**COUNTRY OF BIRTH**

**SSN**

**FOREIGN NATIONAL IDENTIFICATION NUMBER (FINN)**

**FINN COUNTRY OF ISSUE**

**ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK**

**LANGUAGE CODE**

**Home Address**

**NUMBER STREET**

**APT NUMBER**

**CITY**

**STATE**

**ZIP CODE**

**TELEPHONE**

**NOTE:** This information used for application follow-up.

**E-MAIL**

**FAX**

**PREFERRED METHOD OF CONTACT**

**E-MAIL**

**FAX**

---

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

**Page 01**

UDCF 1.1.08
## Section 1
### Personal Information and Professional IDs (Continued)

#### Professional IDs
Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/certifications.

Non-licensed professionals should enter certification/registration number in the space provided for license number.

- **FEDERAL DEA NUMBER**
- **DEA ISSUE DATE (MM/DD/YYYY)**
- **DEA EXPIRATION DATE (MM/DD/YYYY)**
- **DEA STATE OF REGISTRATION**
- **DEA STATE OF REGISTRATION**

- **CDS CERTIFICATE NUMBER**
- **CDS ISSUE DATE (MM/DD/YYYY)**
- **CDS EXPIRATION DATE (MM/DD/YYYY)**
- **CDS STATE OF REGISTRATION**
- **CDS STATE OF REGISTRATION**

If this is a state license, are you currently practicing in this state? **YES** **NO**

Provider Type Code List is found on Page 24.

#### Other ID Numbers
Indicate all that apply.

- **MEDICAID NUMBER**
- **ARE YOU A PARTICIPATING MEDICAID PROVIDER?** **YES** **NO**
- **MEDICAID NUMBER**
- **MEDICAID STATE**
- **NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER**
- **USMLE NUMBER (WITHOUT HYPHENS)**
- **WORKERS COMPENSATION NUMBER**

- **ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)**
- **ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) (MM/DD/YYYY)**

#### License Status
Indicate all that apply.

- **GENERAL DENTAL LICENSE** **YES** **NO**
- **LIMITED DENTAL LICENSE** **YES** **NO**
- **TEMPORARY DENTAL LICENSE** **YES** **NO**
- **INACTIVE DENTAL LICENSE** **YES** **NO**
- **TEACHER'S DENTAL LICENSE** **YES** **NO**
- **OTHER LICENSE STATUS** **YES** **NO**

Status Code List is found on Page 24.

---

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.*

---

UDCF 1.1.08
## Section 2  
**Education and Training**

### Undergraduate School

Provide the appropriate information for the school that issued your undergraduate degree.

<table>
<thead>
<tr>
<th>Field</th>
<th>Instructions</th>
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<tbody>
<tr>
<td><strong>Official Name of Undergraduate School</strong></td>
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<td><strong>Address</strong></td>
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<td><strong>City</strong></td>
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<td><strong>State</strong></td>
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<td><strong>Telephone</strong></td>
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<td><strong>Fax</strong></td>
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<tr>
<td><strong>Start Date</strong> (MM/YYYY)</td>
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<tr>
<td><strong>End Date</strong> (Graduation Date) (MM/YYYY)</td>
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<tr>
<td><strong>Did You Complete Your Undergraduate Education at This School?</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Degree Awarded</strong></td>
<td></td>
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</table>

### Professional School(s)

Provide the appropriate information for the school that issued your professional degree.

- Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

<table>
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<tr>
<th>Field</th>
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<tr>
<td><strong>Graduate Type</strong></td>
<td>U.S. OR CANADIAN GRADUATE  NON-U.S./CANADIAN GRADUATE  FIFTH PATHWAY GRADUATE</td>
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<tr>
<td><strong>U.S. OR CANADIAN SCHOOL</strong></td>
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<tr>
<td><strong>School Code</strong> (U.S./Canadian Only)</td>
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<tr>
<td><strong>Name of U.S./Canadian School</strong></td>
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<td><strong>Start Date</strong> (MM/YYYY)</td>
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<td><strong>End Date</strong> (Graduation Date) (MM/YYYY)</td>
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<tr>
<td><strong>Did You Complete Your Graduate Education at This School?</strong></td>
<td>Yes</td>
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<td><strong>Degree Awarded</strong></td>
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<td><strong>Non-U.S. OR CANADIAN SCHOOL</strong></td>
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<tr>
<td><strong>Official Name of Non-U.S. Professional School</strong></td>
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<td><strong>Did You Complete Your Graduate Education at This School?</strong></td>
<td>Yes</td>
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<td><strong>Degree Awarded</strong></td>
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<td><strong>Degree Awarded</strong></td>
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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.*
## Section 2: Education and Training (Continued)

### Training

List all training programs you attended. Use one section per institution.

Professional School Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

<table>
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<th>FAX</th>
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DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? [ ] YES [ ] NO

IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN:

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NAME OF DIRECTOR

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DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

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NAME OF DIRECTOR

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<td></td>
</tr>
</tbody>
</table>

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

<table>
<thead>
<tr>
<th>DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

NAME OF DIRECTOR

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.
### Section 3

#### Professional / Dental Specialty Information

**Specialty Status**

<table>
<thead>
<tr>
<th>General Dentist</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Primary Specialty</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Primary Specialty**

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

<table>
<thead>
<tr>
<th>Specialty Code</th>
<th>I Have Taken Exam, Results Pending For</th>
<th>Initial Certification Date (MM/DD/YYYY)</th>
<th>Recertification Date (if applicable) (MM/DD/YYYY)</th>
<th>Board Certified?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Certifying Board Code**

If you indicated that you did not intend to take a certifying board exam, please use the following space to explain, otherwise leave the space blank.

**Recertification Date (if applicable) (MM/DD/YYYY)**

**Expiration Date (if applicable) (MM/DD/YYYY)**

**Initial Certification Date (MM/DD/YYYY)**

**Secondary Specialty**

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

<table>
<thead>
<tr>
<th>Specialty Code</th>
<th>I Have Taken Exam, Results Pending For</th>
<th>Initial Certification Date (MM/DD/YYYY)</th>
<th>Recertification Date (if applicable) (MM/DD/YYYY)</th>
<th>Board Certified?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Certifying Board Code**

If you indicated that you did not intend to take a certifying board exam, please use the following space to explain, otherwise leave the space blank.

**Recertification Date (if applicable) (MM/DD/YYYY)**

**Expiration Date (if applicable) (MM/DD/YYYY)**

**Initial Certification Date (MM/DD/YYYY)**

**Primary Credentialing Contact**

Check here to use the office manager and address of the primary practice location on page 7 as the credentialing information.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Number Street</th>
<th>Suite/Building</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Telephone**

**Fax**

**E-mail Address** (Even if you checked the boxes above, please provide the e-mail address, if available.)
### Practice Location Information

#### Section 4

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 19-20.

**NOTE:** If you indicated that you practice exclusively within the inpatient setting on Page 1, you are only required to complete the primary credentialing contact question on Page 5. Section 4 may be left blank and you may proceed to Section 5 on Page 11.

- **Currently Practicing at This Address?**
  - [ ] Yes
  - [ ] No

- **Previous or Future Start Date?**
  - [ ] (MM/DD/YYYY)

- **Dental Group / Practice Name to Appear in Directory (Do Not Abbreviate):**

- **Group / Corporate Name as It Appears on W-9, If Different From Above (Do Not Abbreviate):**

- **Number:**
- **Street:**
- **Suite/Building:**

- **City:**
- **State:**
- **Zip Code:**

- **Send General Correspondence Here?**
  - [ ] Yes
  - [ ] No

- **Telephone:**
- **Fax:**

- **Office E-mail Address:**

- **Primary Tax ID (One Only):**
  - [ ] Use Individual Tax ID
  - [ ] Use Group Tax ID

- **Last Name:**
- **First Name:**
- **M.I.:**

- **Telephone:**
- **Fax:**

- **E-mail Address:**

**Office Manager or Business Office Staff Contact**

List office staff and billing contacts separately. You may use the check boxes below for convenience. Do not write instructions like “see above.” These responses will be rejected and will require follow-up.

- **Last Name:**
- **First Name:**
- **M.I.:**

- **Telephone:**
- **Fax:**

- **E-mail Address:**

**Billing Contact**

- **Last Name:**
- **First Name:**
- **M.I.:**

- **Number:**
- **Street:**
- **Suite/Building:**

- **City:**
- **State:**
- **Zip Code:**

- **Telephone:**
- **Fax:**

- **E-mail Address:**

*REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.*
### Section 4 Practice Location Information (Continued)

#### Payment and Remittance

<table>
<thead>
<tr>
<th>ELECTRONIC BILLING CAPABILITIES?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILLING DEPARTMENT (IF HOSPITAL-BASED)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHECK PAYABLE TO*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Office Hours

(USE HH:MM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

<table>
<thead>
<tr>
<th>DAY</th>
<th>START (A=AM P=PM)</th>
<th>END (A=AM P=PM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONDAY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TUESDAY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WEDNESDAY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THURSDAY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FRIDAY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SATURDAY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUNDAY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24/7 PHONE COVERAGE?*  
YES | NO

ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE
VOICE MAIL WITH OTHER INSTRUCTIONS COVERING COLLEAGUE OTHER

CURRENT WAIT TIME FOR INITIAL APPOINTMENT NUMBER OF OPERATORIES AVAILABLE

#### Open Practice Status

<table>
<thead>
<tr>
<th>ACCEPT NEW PATIENTS INTO THIS PRACTICE?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCEPT ALL NEW PATIENTS?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCEPT NEW MEDICAID PATIENTS?*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?*  
YES | NO

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.
**Section 4  Practice Location Information (Continued)**

**Mid-Level Practitioners**
Identify the primary mid-level practitioners of your practice.

<table>
<thead>
<tr>
<th>PRACTITIONER LAST NAME</th>
<th>PRACTITIONER FIRST NAME</th>
<th>PRACTITIONER LICENSE / CERTIFICATE NUMBER</th>
<th>PRACTITIONER STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.*
## Section 4 Practice Location Information (Continued)

### Languages

Code lists are found on pages 24-25. Enter the associated 3-digit code in the space provided.

<table>
<thead>
<tr>
<th>Languages</th>
<th>LANGUAGE CODE</th>
<th>LANGUAGE CODE</th>
<th>LANGUAGE CODE</th>
<th>LANGUAGE CODE</th>
<th>LANGUAGE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTERPRETERS AVAILABLE?</td>
<td>YES</td>
<td>NO</td>
<td>LANGUAGES INTERPRETED</td>
<td>LANGUAGE CODE</td>
<td>LANGUAGE CODE</td>
</tr>
</tbody>
</table>

### Accessibilities

Does this office meet ADA accessibility requirements?* YES NO

Does this site offer handicapped access for the following?

- Building? YES NO
- Parking? YES NO
- Restroom? YES NO

Does this site offer other services for the disabled?* YES NO

- Text Telephony (TTY)? YES NO
- American Sign Language? YES NO
- Mental/Physical Impairment Services? YES NO
- TDD/Hearing Impaired? YES NO

Other Handicapped Access

Other Transportation Access

### Certifications

Do you hold the following certifications? If yes, provide expiration dates.

- Basic Life Support YES NO
- CPR YES NO

### Services

Does this location provide any of the following services?

- Radiology Services? YES NO
- Anesthesia Services? YES NO

If yes, who administers it?

- Last Name
- First Name

Sterilization methods used:

- Autoclave YES NO
- Chemclave YES NO
- Other YES NO

Type of Practice (Select one only)*

- Solo Practice
- Single Specialty Group
- Multi-Specialty Group
- Corporation
- LLC
- Other

Additional Office Procedures Provided (Including Surgical Procedures)

---

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.
### Partners/Associates

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>SPECIALTY CODE</th>
<th>COVERING COLLEAGUE (Y/N)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DO YOU HAVE MORE THAN THREE PARTNERS/ASSOCIATES AT THIS PRACTICE?  YES NO IF MORE THAN THREE, HOW MANY?

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>SPECIALTY CODE</th>
<th>COVERING COLLEAGUE (Y/N)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>SPECIALTY CODE</th>
<th>COVERING COLLEAGUE (Y/N)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Covering Colleagues

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>SPECIALTY CODE</th>
<th>COVERING COLLEAGUE (Y/N)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DO YOU HAVE MORE THAN TWO COVERING COLLEAGUES AT THIS PRACTICE?  YES NO IF MORE THAN TWO, HOW MANY?

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>SPECIALTY CODE</th>
<th>COVERING COLLEAGUE (Y/N)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Hospital Affiliations

Admitting Arrangements

<table>
<thead>
<tr>
<th>DO YOU HAVE HOSPITAL PRIVILEGES?</th>
<th>YES NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>DO YOU HAVE HOSPITAL PRIVILEGES AT MORE THAN ONE HOSPITAL?</td>
<td>YES NO</td>
</tr>
</tbody>
</table>

IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.
## Section 5
### Hospital Affiliations (Continued)

**Hospital Privileges**
If applicable, list primary hospital affiliation then secondary or other current affiliation.

<table>
<thead>
<tr>
<th>HOSPITAL NAME</th>
<th>NUMBER STREET</th>
<th>SUITE/BUILDING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PRIMARY HOSPITAL**

<table>
<thead>
<tr>
<th>DEPARTMENT NAME</th>
<th>NUMBER STREET</th>
<th>SUITE/BUILDING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HOSPITAL NAME**

<table>
<thead>
<tr>
<th>DEPARTMENT NAME</th>
<th>NUMBER STREET</th>
<th>SUITE/BUILDING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Affiliation Start Date (MM/YYYY)**

**Affiliation End Date (MM/YYYY)**

**Admitting Privilege Status (e.g. None, Full Unrestricted, Provisional, Temporary)**

<table>
<thead>
<tr>
<th>Percent of Annual Admissions to This Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**OTHER HOSPITAL**

<table>
<thead>
<tr>
<th>DEPARTMENT NAME</th>
<th>NUMBER STREET</th>
<th>SUITE/BUILDING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Affiliation Start Date (MM/YYYY)**

**Affiliation End Date (MM/YYYY)**

**Admitting Privilege Status (e.g. None, Full Unrestricted, Provisional, Temporary)**

<table>
<thead>
<tr>
<th>Percent of Annual Admissions to This Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.
### Section 6
**Professional Liability Insurance Carrier**

<table>
<thead>
<tr>
<th>CARRIER OR SELF-INSURED NAME</th>
<th>SELF-INSURED?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STREET</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUITE/BUILDING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STATE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZIP CODE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORIGINAL EFFECTIVE DATE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EFFECTIVE DATE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXPIRATION DATE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>AMOUNT OF COVERAGE PER OCCURRENCE</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMOUNT OF COVERAGE AGGREGATE</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Policy Number**

<table>
<thead>
<tr>
<th>TYPE OF COVERAGE?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDIVIDUAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHARED</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Type of Coverage?**

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHARED</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section 7
**Work History and References**

**Military Duty**

Are you currently on active military duty or military reserve?*

**Work History**

Include a chronological work history for the past 10 years, excluding current positions listed in section 4.

A longer period may be required by your dental plan organization.
Section 7  Work History and References (Continued)

**Work History**

Do not list current positions. Those should be listed in Section 4.

Include a chronological work history for the past 10 years.

A longer period may be required by your dental plan organization.

<table>
<thead>
<tr>
<th>PRACTICE / EMPLOYER NAME</th>
<th>NUMBER STREET</th>
<th>SUITE/BUILDING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP/POSTAL CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TELEPHONE</th>
<th>FAX</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COUNTRY CODE</th>
<th>START DATE (MM/YYYY)</th>
<th>END DATE (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reason for Departure (If Applicable)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.*
### Section 7: Work History and References (Continued)

#### Gaps in Professional / Work History

PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALED.

<table>
<thead>
<tr>
<th>GAP START DATE (MM/YYYY)</th>
<th>GAP END DATE (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

---

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.
### Section 7  Work History and References (Continued)

#### Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Code lists are found on pages 24-26. Enter the associated 3-digit code for provider type.

**NOTE:**
You are required to provide exactly 3 references. Your application will not be complete without this information.

Please check with credentialing entity for any special requirements.

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>PROVIDER TYPE (CODE PG 24)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>STREET</th>
<th>APT/SUITE/BUILDING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TELEPHONE</th>
<th>FAX</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Section 8 Disclosure Questions**

*REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.*

<table>
<thead>
<tr>
<th>Disclosure Questions</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has there been any challenge to your licensure, registration or certification?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, 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 record 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?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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, dental plans, or provider organizations?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you, or your business entity, own, have an investment in, manage, own stock in, participate in a joint venture, or act as a partner, contract consultant or medical/dental advisor in any medical/dental enterprise or medical/dental supplier outside of your direct practice where you would financially benefit directly or indirectly?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you currently the subject of an investigation by any hospital, licensing authority, education or training program, Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been convicted of, pled guilty to, pled no contest to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.*
# Section 8: Disclosure Questions

For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 22.

**IMPORTANT**
If you answered "Yes" to question #19, you must complete the Supplemental Malpractice Claims Explanation Form on page 23 for each malpractice claim.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>19.</td>
<td><strong>YES</strong></td>
<td><strong>NO</strong></td>
<td>Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td><strong>YES</strong></td>
<td><strong>NO</strong></td>
<td>Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td><strong>YES</strong></td>
<td><strong>NO</strong></td>
<td>In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td><strong>YES</strong></td>
<td><strong>NO</strong></td>
<td>Have you ever been court-martialed for actions related to your duties as a medical professional?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td><strong>YES</strong></td>
<td><strong>NO</strong></td>
<td>Are you currently engaged in the illegal use of drugs? (&quot;Currently&quot; means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice dentistry. 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. &quot;Illegal use of drugs&quot; refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812. 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.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td><strong>YES</strong></td>
<td><strong>NO</strong></td>
<td>Do you use any chemical substances that would in any way impair or limit your ability to practice dentistry and perform the functions of your job with reasonable skill and safety?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td><strong>YES</strong></td>
<td><strong>NO</strong></td>
<td>Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td><strong>YES</strong></td>
<td><strong>NO</strong></td>
<td>Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.
Standard Authorization, Attestation and Release

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), 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.

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 "Agent(s)"); 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 and copy 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, dental groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, dental or health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, credentialing and accreditation agencies, professional dental societies, state dental 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. All information released to a third party shall be limited to the Entity's representatives, employees, and/or its Agent(s) which prepares the application.

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 healthcare 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 of 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 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 current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) 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 online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. 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 and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

DATE SIGNED (MM/DD/YYYY)*

Name (print)*
### Practice Location Information Supplemental Form

**Section 1**

**Additional Practice Location**

<table>
<thead>
<tr>
<th>LOCATION #</th>
<th>REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.</th>
</tr>
</thead>
</table>

**IMPORTANT**

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

**TIP**

Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

---

**Office Manager or Business Office Contact**

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

---

**Billing Contact**

Check here to use Office Manager and Office Address as Billing Information.

---

**NOTE:**

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

---

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.
## Practice Location Information Supplemental Form

*REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.*

### Section 1

<table>
<thead>
<tr>
<th>Practice Location Information - Page 2 of 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Add'l Practice Location (Cont.)</strong></td>
</tr>
</tbody>
</table>

**LOCATION #**

**Electronic Billing Capabilities**

- [ ] YES
- [x] NO

**Billing Department (If hospital-based)**

**Check Payable To**

**Last Name**

**First Name**

**M.I.**

**Number**

**Street**

**Suite/Building**

**City**

**State**

**Zip Code**

**Telephone**

**Fax**

**E-mail Address**

**Office Hours**

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

<table>
<thead>
<tr>
<th>START</th>
<th>A=AM P=PM</th>
<th>END</th>
<th>A=AM P=PM</th>
<th>START</th>
<th>A=AM P=PM</th>
<th>END</th>
<th>A=AM P=PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONDAY</td>
<td></td>
<td></td>
<td></td>
<td>FREDAY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TUESDAY</td>
<td></td>
<td></td>
<td></td>
<td>SATURDAY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WEDNESDAY</td>
<td></td>
<td></td>
<td></td>
<td>SUNDAY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THURSDAY</td>
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</tr>
</tbody>
</table>

**24/7 Phone Coverage**

- [ ] YES
- [ ] NO

**Answering Service**

**Voice Mail With Instructions To Call Answering Service**

**Voice Mail With Other Instructions**

**Covering Colleague**

### Open Practice Status

- **Accept New Patients Into This Practice?**
  - [ ] YES
  - [ ] NO

- **Accept All New Patients?**
  - [ ] YES
  - [ ] NO

- **Accept Existing Patients With Change Of Payor?**
  - [ ] YES
  - [ ] NO

- **Accept New Medicaid Patients?**
  - [ ] YES
  - [ ] NO

- **Accept New Patients With Physician Referral?**
  - [ ] YES
  - [ ] NO

**If Any Of The Above Information Varies By Plan, Explain**

**Are There Any Practice Limitations?**

- [ ] YES
- [ ] NO

**If Yes, Explain**

**Current Wait Time For Initial Appointment**

**Number Of Operators Available**

*REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.*
### Professional Liability Insurance Carrier
#### Supplemental Form

**Section 2**

**Other Professional Liability Insurance Carrier**

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage.

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

<table>
<thead>
<tr>
<th>CARRIER OR SELF-INSURED NAME</th>
<th>SELF-INSURED?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER</td>
<td>STREET*</td>
<td>SUITE/BUILDING</td>
<td></td>
</tr>
<tr>
<td>CITY*</td>
<td>STATE*</td>
<td>ZIP CODE*</td>
<td></td>
</tr>
<tr>
<td>ORIGINAL EFFECTIVE DATE*</td>
<td>EFFECTIVE DATE* (MM/YYYY)</td>
<td>EXPIRATION DATE (MM/YYYY)</td>
<td></td>
</tr>
<tr>
<td>DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>AMOUNT OF COVERAGE PER OCCURRENCE</td>
<td>AMOUNT OF COVERAGE AGGREGATE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POLICY INCLUDES TAIL COVERAGE?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>POLICY NUMBER*</td>
<td></td>
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</tr>
</tbody>
</table>

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**Other Professional Liability Insurance Carrier**

List secondary / second layer / future or previous carrier(s).

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

<table>
<thead>
<tr>
<th>CARRIER OR SELF-INSURED NAME</th>
<th>SELF-INSURED?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER</td>
<td>STREET*</td>
<td>SUITE/BUILDING</td>
<td></td>
</tr>
<tr>
<td>CITY*</td>
<td>STATE*</td>
<td>ZIP CODE*</td>
<td></td>
</tr>
<tr>
<td>ORIGINAL EFFECTIVE DATE*</td>
<td>EFFECTIVE DATE* (MM/YYYY)</td>
<td>EXPIRATION DATE (MM/YYYY)</td>
<td></td>
</tr>
<tr>
<td>DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>AMOUNT OF COVERAGE PER OCCURRENCE</td>
<td>AMOUNT OF COVERAGE AGGREGATE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POLICY INCLUDES TAIL COVERAGE?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>POLICY NUMBER*</td>
<td></td>
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</tbody>
</table>
Disclosure Questions
Supplemental Form

Section 3
Disclosure Questions

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. Your response should not exceed the spaces provided.

Record the question number in the first column, then your explanation in the second column.

If you need additional space to explain a "Yes" response, photocopy this page as needed and submit as instructed.

<table>
<thead>
<tr>
<th>QUESTION #</th>
<th>EXPLANATION</th>
</tr>
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<tbody>
<tr>
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</table>

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.
# Malpractice Claims Explanation Supplemental Form

### Section 4

**Malpractice Claims Explanation**

Use this form to report any “Yes” response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

<table>
<thead>
<tr>
<th><strong>DATE OF OCCURRENCE</strong>&lt;br&gt; (MM/DD/YYYY)</th>
<th><strong>DATE CLAIM WAS FILED</strong>&lt;br&gt; (MM/DD/YYYY)</th>
</tr>
</thead>
</table>

**STATUS OF CLAIM** *(NOTE: IF CASE IS PENDING, SELECT OPEN)*

<table>
<thead>
<tr>
<th>OPEN</th>
<th>CLOSED</th>
</tr>
</thead>
</table>

**IF SETTLED, ENTER DATE CLAIM WAS SETTLED** *(MM/DD/YYYY)*

**PROFESSIONAL LIABILITY CARRIER INVOLVED** *(USE BOTH LINES IF NECESSARY)*

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>STREET</th>
<th>SUITE/BUILDING</th>
</tr>
</thead>
</table>

**CITY**

<table>
<thead>
<tr>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
</table>

**TELEPHONE**

**POLICY NUMBER**

**DATE CLAI$$WAS FILE$$D** *(MM/DD/YYYY)*

**AMOUNT OF AWARD OR SETTLEMENT**

<table>
<thead>
<tr>
<th>DISMISSED</th>
<th>SETTLED</th>
<th>MEDIATION</th>
<th>ARBITRATION</th>
</tr>
</thead>
</table>

**METHOD OF RESOLUTION** *(USE ALL THREE LINES IF NECESSARY)*

**DESCRIPTION OF ALLEGATIONS** *(USE ALL FOUR LINES BELOW, IF NECESSARY)*

**WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT** *(USE ALL THREE LINES IF NECESSARY)*

<table>
<thead>
<tr>
<th>PRIMARY DEFENDANT</th>
<th>CO-DEFENDANT</th>
<th>NUMBER OF OTHER CO-DEFENDANTS (IF ANY)</th>
</tr>
</thead>
</table>

**YOUR INVOLVEMENT IN CASE** *(ATTENDING, CONSULTING, ETC)*

**DESCRIPTION OF ALLEGED INJURY TO THE PATIENT** *(USE ALL FOUR LINES BELOW, IF NECESSARY)*

**DID THE ALLEGED INJURY RESULT IN DEATH** *(USE ALL THREE LINES IF NECESSARY)*

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)** *(USE ALL THREE LINES IF NECESSARY)*

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

*REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.*
Code Lists

Provider Type Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Medical Doctor (MD)</td>
</tr>
<tr>
<td>002</td>
<td>Doctor of Dental Surgery (DDS)</td>
</tr>
<tr>
<td>003</td>
<td>Doctor of Dental Medicine (DMD)</td>
</tr>
</tbody>
</table>

License Status Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Active</td>
</tr>
<tr>
<td>002</td>
<td>Canceled</td>
</tr>
<tr>
<td>003</td>
<td>Denied</td>
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### Code Lists

#### U.S. / Canadian Professional School Codes (continued)

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<td>University of Texas Health Science Center at San Antonio Dental School</td>
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#### Specialty Codes - DDS / DMD

**NOTE:** This list is from the National Health Care Provider Taxonomy Code List, published in cooperation with the National Uniform Claim Committee (NUCC).

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<td>Dentist, Dental Public Health</td>
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<td>Dentist, Endodontics</td>
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<td>Dentist, General Practice</td>
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<table>
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<td>109</td>
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| 112 | American Board of Pediatric Dentistry |
| 111 | American Board of Periodontology |
| 115 | American Board of Prosthodontics |
| 106 | American Board of Public Health Dentistry |
| 120 | Boards other than ABMS/AOA |
Primary Dental Office Agreement

with United Concordia Companies, Inc. and
Its Affiliated Organizations
for Capitated Dental Managed Care Programs

Under the applicable laws of the State of Maryland, I (we) am (are) (hereinafter "Primary Dental Office") duly authorized to engage in the practice of dentistry. In consideration for being registered as a participating Primary Dental Office for the ConcordiaPLUS network of United Concordia Companies, Inc. and its affiliated organizations (hereinafter collectively "United Concordia"), I (we) do hereby agree to all provisions of this Primary Dental Office Agreement (the "Agreement") as follows:

A. Obligations of the Primary Dental Office

The Primary Dental Office:

1. Will provide dental services covered under each Group's benefit plan, as defined in the applicable Certificates of Coverage, master contracts, and administrative agreements to those Members who are enrolled at the Primary Dental Office in a United Concordia capitated dental managed care program (hereinafter "Plan"). The Primary Dental Office agrees to listing of the office in Plan directories of participating dental providers.

2. Agrees to refer Members for dental specialty care only to Specialty Care Dentists who have entered into a Specialty Care Agreement with United Concordia and to adhere to the Plan's referral authorization procedures, if applicable.

3. Agrees that the capitation payment, appropriate copayments or deductibles, and any applicable Provider Protection Plan supplemental payments shall constitute payment in full. The Primary Dental Office will hold members harmless for any amount in excess of this reimbursement. The capitation amounts and copayment schedules are set forth as Schedules A and B, respectively. The Primary Dental Office agrees that under no circumstances, including non-payment by United Concordia, shall the Primary Dental Office seek payment from an Enrollee for services rendered under this Agreement for other than a Copayment listed on the Member Copayment Schedule. The Primary Dental Office further agrees that this provision shall survive the termination of this Agreement regardless of the cause of the termination.

4. Will accept as patients all Members who are registered in their dental office and schedule appointments for all Members using the same standards applicable to all other patients and without discrimination on the basis of sex, race, nationality, religion, health, insurance status, economic status, or hours of operation. The Primary Dental Office will notify United Concordia of any change in hours of operation, location or change of ownership.
5. May request to "hold" the number of members assigned to their office by providing sixty (60) days written notice to United Concordia. The Primary Dental Office is excluded from any applicable Provider Protection Plans for the period such office is on "hold" (not accepting new members).

6. Shall be responsible, at all times, for maintaining emergency coverage, provided in accordance with the guidelines of the American Dental Association ("ADA") or applicable law.

7. Will maintain accurate and complete dental records for all Members enrolled in the Plan and will report to United Concordia all covered services provided to Plan Members within forty-five (45) days following the date the services were rendered using a standard ADA format or other format approved by United Concordia and consistent with the Group’s Agreement.

8. Will provide information to United Concordia relative to Members who may be entitled to receive benefits under any other group plan for Dental Services covered by this Agreement or under any governmental program for which any periodic payment is made by or for the Member. In addition, the Primary Dental Office agrees to abide by the Coordination of Benefits provision delineated in the applicable Certificate of Coverage.

9. Will participate fully in the Quality Review Program and Member Grievance Process, as amended from time to time by United Concordia, and will comply with any reasonable request for a quality assessment review and provide timely responses and documentation relative to any Member grievance upon notification by United Concordia.

10. Will have/obtain professional liability (malpractice) insurance coverage in the amount specified on Schedule C (or such greater amount as may be required by law) from a carrier authorized to do business in the state of the Primary Dental Office's practice and shall maintain such insurance throughout the term of this Agreement for all providers in the office covered under this Agreement. The Primary Dental Office will provide information necessary for provider credentialing on any and all dentists providing services under this Agreement on a permanent, part-time or substitution basis, as well as timely notification to United Concordia of any change to the dentist(s) credentials or license to practice.

11. Warrants and represents that the party executing this Agreement on behalf of the Primary Dental Office has authority to do so and to bind the Primary Dental Office and all individual dentists practicing at the Primary Dental Office to the terms and conditions herein. A list of dentists practicing at the Primary Dental Office is attached hereto as Schedule D. The Primary Dental Office shall update this Schedule within fifteen (15) days of any change.

12. Will not during the term of this Agreement and for a period of two years after termination of this Agreement directly or indirectly engage in the solicitation of Members to disenroll and/or join any other dental benefit program, particularly any program in which the Dentist(s) has a financial interest or receives a monetary or material incentive, and acknowledges that this is a reasonable and necessary protection to United Concordia and that any violation of this provision would result in irreparable damage to United Concordia. In the event of a violation of this provision, United Concordia shall be entitled to any legal or equitable remedy to protect its interest.

13. Shall notify each Member of the termination of the Member’s Group Agreement if the Member visits the Primary Dental Office when the Primary Dental Office is aware that the Group Agreement has terminated.
Under these circumstances, the Primary Dental Office shall inform the Member of the charge for any scheduled dental services before performing the dental services.

B. Obligations of United Concordia and Its Affiliated Organizations

United Concordia:

1. Will furnish the Primary Dental Office a monthly eligibility list of Members, including names, types and effective dates of coverage.

2. Will pay to the Primary Dental Office, a monthly capitation payment for each Member entitled to benefits at that office under the applicable Plan. Capitation payments shall vary depending on the particular Plan. Capitation payments and patient copayments will be reviewed and adjusted periodically. Copayment schedules for each Plan will be provided to the Primary Dental Office.

3. Will provide the Primary Dental Office with patient encounter forms upon request or electronic access to report all services provided to capitated Members.

4. Will furnish the Primary Dental Office with resource materials: e.g., a Primary Dental Office Manual setting out the procedures of United Concordia and will provide and update group benefit and copayment reports.

5. Will establish and administer a Quality Review Program utilizing a continuous improvement model. A copy of the Quality Review Program will be furnished to the Primary Dental Office.

6. Will conduct periodic evaluations of the Primary Dental Office's facility and treatment records as part of the Quality Review Program.

7. Will provide Provider protection payments, at United Concordia’s discretion, in those cases in which United Concordia determines that aggregate compensation (capitation plus copayments) is inadequate for the dental services rendered by the Primary Dental Office. After performing a utilization analysis from the patient encounter data submitted by the Primary Dental Office, United Concordia will make periodic determinations and a cumulative annualized settlement. Provider protection payments will be made only to those Primary Dental Offices which are accepting new patients in all United Concordia programs.

United Concordia reserves the right to audit all utilization data submitted; all utilization data must be received no later than fifteen (15) working days following the quarter in which the services were rendered.

8. Will establish a grievance committee for the investigation and resolution of member complaints relative to care administered by a Primary Dental Office.
C. **Relationship of the Parties**

*United Concordia and the Primary Dental Office:*

1. United Concordia shall not be liable for injuries or damages resulting from acts or omissions of any Primary Dental Office, employee of any Primary Dental Office or other person furnishing services or supplies to the Member.

2. United Concordia shall not hold a Primary Dental Office responsible for any acts or obligations of any other Primary Dental Office or any other persons furnishing dental services or supplies to the Member.

3. None of the provisions of this Agreement are intended to create, nor shall be deemed to create, any relationship between the parties other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be considered to be the agent, employer, employee or representative of the other.

4. United Concordia agrees to defend and hold harmless the Primary Dental Office in connection with any claim or cause of action which is asserted against the Primary Dental Office based upon the sole fact of its participation in the Plan. If the claim or cause of action includes facts which could have been alleged irrespective of the Primary Dental Office participation in the Plan, United Concordia will have no obligation to defend and hold harmless the Primary Dental Office in connection with those allegations. Furthermore, in no event shall United Concordia have any obligation to defend and hold harmless the Primary Dental Office in connection with injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of the Primary Dental Office in the course of rendering services to Members enrolled under the Plan or to any other patient.

5. The Primary Dental Office agrees that in no event, including, but not limited to non-payment by United Concordia, or insolvency or breach of this Agreement by United Concordia, shall the Primary Dental Office bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or person(s) other than United Concordia acting on the Member's behalf for covered services. This provision shall not prohibit collection of applicable coinsurances, copayments or deductibles in accordance with the terms of the Certificates of Coverage, master contracts, and administrative agreements.

   The Primary Dental Office further agrees that, (1) the hold harmless provision herein shall survive the termination of this Agreement, regardless of the cause giving rise to such termination; and that, (2) this hold harmless provision supersedes any oral or written contractual agreement now existing or hereafter entered into between the Primary Dental Office and the Member or person(s) acting on his/her behalf.

D. **Good Faith**

1. Both parties enter this Agreement as independent contracting entities in good faith and will strive to adhere to the intent and provisions thereof. All information provided to the Primary Dental Office under this Agreement is proprietary and not to be disclosed to any other party.
2. In the event of a complaint regarding this Agreement, the complaining party agrees to notify the other party in writing, outlining the nature of the complaint.

3. The recipient of a complaint agrees to respond in writing to such complaints within fifteen (15) working days of receipt of the complaint and to act in good faith toward a mutually acceptable solution.

4. These provisions in no way waive or affect the right of either party to terminate this Agreement.

E. Term and Termination; Assignment; Regulatory Approval

This Agreement shall be effective immediately for an initial term of one (1) year and shall continue in effect thereafter from year to year, until terminated by either party according to the following provisions:

1. United Concordia may terminate this Agreement during the initial term or any point thereafter upon written notice if the Primary Dental Office or any dentist of the Primary Dental Office fails to maintain a legally qualified license to practice dentistry or commits unethical or unprofessional acts or if Dentist fails to comply with the terms of this Agreement.

2. After the initial term of one (1) year, this Agreement may be terminated by either party upon ninety (90) days written notice for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status by the Primary Dentist. The Primary Dental Office will continue to provide services for enrolled Members until they can be transferred to another acceptable Primary Dental Office or for ninety (90) days from United Concordia's receipt of notice of termination, whichever comes sooner. The Primary Dental Office may not terminate this Agreement during the initial term unless the Primary Dental Office becomes unavailable during the initial term for reasons beyond the control of United Concordia or the Primary Dental Office, as set forth in the applicable Certificate of Coverage.

3. For a period of at least ninety (90) days from the date of the notice of a Primary Dental Office’s termination from the Plan for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status, the Primary Dental Office shall render dental services to any of the Plan’s Enrollees who:
   a. Were receiving health care services from the Primary Dental Office prior to the notice of termination; and
   b. Request, after receiving notice of the Primary Dental Office’s termination, to continue receiving dental services from the Primary Dental Office.

4. This Agreement shall be assignable by United Concordia but only to a subsidiary, affiliate, or successor corporation of United Concordia.

5. In the event that United Concordia Companies, Inc., or the appropriate affiliated organization has not been licensed or has not obtained any applicable regulatory approval for the use of this Agreement prior to the execution of this Agreement, this Agreement shall
become effective upon such licensing or approval, as applicable. If unable to obtain such licensure or approval after due diligence, United Concordia shall notify the Primary Dental Office and both parties shall be released from any liability under this Agreement; provided however, that if such licensure or approval is obtained upon condition of amendments to this Agreement, such amendments will be provided to the Primary Dental Office.

6. The interpretation of this Agreement is governed by the laws of the State of Maryland.

UNITED CONCORDIA COMPANIES, INC.

Date: __________________ By: _________________________________________________
Print: ____________________________
Title: _____________________________

PROVIDER:

Date: __________________

By: _____________________________
(Please Print)

Telephone No.: (  )___________

Signature: _________________________

SS No. _________________________

Address: _________________________

Tax ID No.: ______________________

License No.: ______________________
Schedule A

Capitation Amounts

To obtain current capitation amounts by plan, visit www.unitedconcordia.com.
Schedule B

Copayment Schedules

Copayment Schedules are available upon request by calling our Interactive Voice Response (IVR) system at (866) 357-3304 or by utilizing My Patients’ Benefits at www.unitedconcordia.com. Copayment schedules are also mailed directly to Primary Dental Offices as updates are made.
Schedule C

Malpractice Insurance Requirements

Each Dentist shall maintain professional liability limits no less than $1,000,000 per occurrence/$3,000,000 aggregate, and shall comply with the provisions of Section A.10 of the Primary Dental Office Agreement.
## Schedule D

**List of Participating Dentists at the Primary Dental Office**

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* (Name of dentist who executes agreement), has been authorized by me to bind me to the terms and conditions herein. No further action on my part is required to effectuate this authorization. My signature on this page is not required to effectuate this authorization, but rather indicates that I, personally, have had the opportunity to read the attached Agreement and its Exhibits, and that I agree to be bound by them.

**NOTE:**

**Attached is part II of Schedule D - copy of application showing the address and hours of operation**
The Primary Dental Office Agreement With United Concordia Companies, Inc. and its Affiliated Organizations for Capitated Dental Managed Care Programs (the “Agreement”) is hereby amended as follows:

A. Obligations of the Primary Dental Office

Replace provision A. 7. with the following:

7. Will maintain accurate and complete dental records for all Members enrolled in the Plan and will report to United Concordia all covered services provided to Plan Members within one hundred eighty (180) days following the date the services were rendered using a standard ADA format or other format approved by United Concordia and consistent with the Group’s Agreement.
PRIMARY DENTAL OFFICE AGREEMENT
with United Concordia Companies, Inc. and
Its Affiliated Organizations
for Capitated Dental Managed Care Programs

Under the applicable laws of the Commonwealth of Virginia, I (we) am (are) (hereinafter "Primary Dental Office") duly authorized to engage in the practice of dentistry. In consideration for being registered as a participating Primary Dental Office for the ConcordiaPLUS network of United Concordia Companies, Inc. and its affiliated organizations identified in Schedule A, as supplemented from time to time (hereinafter collectively "United Concordia"), I (we) do hereby agree to all provisions of this Primary Dental Office Agreement (the "Agreement") as follows:

A. Obligations of the Primary Dental Office

The Primary Dental Office:

1. Will provide dental services covered under each Group's benefit plan, as defined in the applicable Certificates of Coverage, master contracts, and administrative agreements to those Members who are enrolled at the Primary Dental Office in a United Concordia capitated dental managed care program (hereinafter "Plan"). The Primary Dental Office agrees to listing of the office in Plan directories of participating dental providers.

2. Agrees to refer Members for dental specialty care only to Specialty Care Dentists who have entered into a Specialty Care Agreement with United Concordia and to adhere to the Plan's referral authorization procedures, if applicable.

3. Agrees that the capitation payment, appropriate copayments, and any applicable Provider Protection Plan supplemental payments shall constitute payment in full. The Primary Dental Office will hold members harmless for any amount in excess of this reimbursement. The capitation amounts and copayment schedules are set forth as Schedule B.

4. Will accept as patients all Members who select the office as their dental site and schedule appointments for all Members using the same standards applicable to all other patients and without discrimination on the basis of sex, race, nationality, religion, health, insurance status, economic status, or hours of operation. The Primary Dental Office will notify United Concordia of any change in hours of operation, location or change of ownership.

5. May request to "hold" the number of members assigned to their office by providing sixty (60) days written notice to United Concordia. The Primary Dental Office is excluded from any applicable Provider Protection Plans for the period such office is on "hold" (not accepting new members).
6. Shall be responsible, at all times, for maintaining emergency coverage, provided in accordance with the guidelines of the American Dental Association ("ADA") or applicable law.

7. Will maintain accurate and complete dental records for all Members enrolled in the Plan and will report to United Concordia all covered services provided to Plan Members within forty-five (45) days following the date the services were rendered using a standard ADA format or other format approved by United Concordia.

8. Will provide information to United Concordia relative to Members who may be entitled to receive benefits under any other group plan for Dental Services covered by this Agreement or under any governmental program for which any periodic payment is made by or for the Member. In addition, the Primary Dental Office agrees to abide by the Coordination of Benefits provision delineated in the applicable Certificate of Coverage.

9. Will participate fully in the Quality Review Program and Member Grievance Process, as amended from time to time by United Concordia, and will comply with any reasonable request for a quality assessment review and provide timely responses and documentation relative to any Member grievance upon notification by United Concordia.

10. Will have/obtain professional liability (malpractice) insurance coverage in the amount specified on Schedule C (or such greater amount as may be required by law) from a carrier authorized to do business in the state of the Primary Dental Office's practice and shall maintain such insurance throughout the term of this Agreement for all providers in the office covered under this Agreement. The Primary Dental Office will provide information necessary for provider credentialing on any and all dentists providing services under this Agreement on a permanent, part-time or substitution basis, as well as timely notification to United Concordia of any change to the dentist(s) credentials or license to practice.

11. Warrants and represents that the party executing this Agreement on behalf of the Primary Dental Office has authority to do so and to bind the Primary Dental Office and all individual dentists practicing at the Primary Dental Office to the terms and conditions herein. A list of dentists practicing at the Primary Dental Office is attached hereto as Schedule D. The Primary Dental Office shall update this Schedule within fifteen (15) days of any change.

12. Will not during the term of this Agreement and for a period of two years after termination of this Agreement directly or indirectly engage in the solicitation of Members to disenroll and/or join any other dental benefit program, particularly any program in which the Dentist(s) has a financial interest or receives a monetary or material incentive, and acknowledges that this is a reasonable and necessary protection to United Concordia and that any violation of this provision would result in irreparable damage to United Concordia. In the event of a violation of this provision, United Concordia shall be entitled to any legal or equitable remedy to protect its interest.
B. Obligations of United Concordia and Its Affiliated Organizations

United Concordia:

1. Will furnish the Primary Dental Office a monthly eligibility list of Members, including names, types and effective dates of coverage.

2. Will pay to the Primary Dental Office, a monthly capitation payment for each Member entitled to benefits at that office under the applicable Plan. Capitation payments shall vary depending on the particular Plan. Capitation payments and patient copayments will be reviewed and adjusted periodically. Copayment schedules for each Plan will be provided to the Primary Dental Office.

3. Will provide the Primary Dental Office with patient encounter forms or electronic access to report all services provided to capitated Members.

4. Will furnish the Primary Dental Office with resource materials: e.g., a Primary Dental Office Manual setting out the procedures of United Concordia and will provide and update group benefit and copayment reports.

5. Will establish and administer a Quality Review Program utilizing a continuous improvement model. A copy of the Quality Review Program will be furnished to the Primary Dental Office.

6. Will conduct periodic evaluations of the Primary Dental Office's facility and treatment records as part of the Quality Review Program.

7. Will provide Provider protection payments, at United Concordia’s discretion, in those cases in which United Concordia determines that aggregate compensation (capitation plus copayments) is inadequate for the dental services rendered by the Primary Dental Office. After performing a utilization analysis from the patient encounter forms submitted by the Primary Dental Office, United Concordia will make quarterly determinations and a cumulative annualized settlement. Provider protection payments will be made only to those Primary Dental Offices which are accepting new patients in all United Concordia programs at the time such payments are to be made.

    United Concordia reserves the right to audit all utilization data submitted; all utilization data must be received no later than fifteen (15) working days following the quarter in which the services were rendered.

8. Will establish a grievance committee for the investigation and resolution of member complaints relative to care administered by a Primary Dental Office.
C. **Relationship of the Parties**

**United Concordia and the Primary Dental Office:**

1. United Concordia shall not be liable for injuries or damages resulting from acts or omissions of any Primary Dental Office, employee of any Primary Dental Office or other person furnishing services or supplies to the Member.

2. United Concordia shall not hold a Primary Dental Office responsible for any acts or obligations of any other Primary Dental Office or any other persons furnishing dental services or supplies to the Member.

3. None of the provisions of this Agreement are intended to create, nor shall be deemed to create, any relationship between the parties other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be considered to be the agent, employer, employee or representative of the other.

4. United Concordia agrees to defend and hold harmless the Primary Dental Office in connection with any claim or cause of action which is asserted against the Primary Dental Office based upon the sole fact of its participation in the Plan. If the claim or cause of action includes facts which could have been alleged irrespective of the Primary Dental Office participation in the Plan, United Concordia will have no obligation to defend and hold harmless the Primary Dental Office in connection with those allegations. Furthermore, in no event shall United Concordia have any obligation to defend and hold harmless the Primary Dental Office in connection with injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of the Primary Dental Office in the course of rendering services to Members enrolled under the Plan or to any other patient.

5. The Primary Dental Office agrees that in no event, including, but not limited to non-payment by United Concordia, or any health maintenance organization (“the health maintenance organization”) licensed by and doing business in the Commonwealth of Virginia which is authorized to sell a JustDental or United Concordia product; or United Concordia’s or the health maintenance organization’s insolvency or breach of this Agreement by United Concordia, shall the Primary Dental Office bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or person(s) other than United Concordia acting on the Member's behalf or the health maintenance organization for covered services. This provision shall not prohibit collection of co-insurances or copayments in accordance with the terms of the Certificates of Coverage, master contracts, and administrative agreements.

   The Primary Dental Office further agrees that, (1) the hold harmless provision herein shall survive the termination of this Agreement, regardless of the cause giving rise to such termination; and that, (2) this hold harmless provision supersedes any oral or written contractual agreement now existing or hereafter entered into between the Primary Dental Office and the Member or person(s) acting on his/her behalf.

   Any modifications, additions, or deletions to the provisions of this hold harmless clause shall become effective on a date no earlier than fifteen (15) days after the Commonwealth of
Virginia State Corporation Commission Bureau of Insurance has received written notice of such proposed changes.

6. Pursuant to Section 38.2 - 4505 of the Code of Virginia, all participating Virginia Primary Dental Offices in United Concordia’s ConcordiaPLUS network shall be jointly and severally liable on all Virginia contracts made for the purpose of United Concordia by United Concordia as agent for them. In the event of the resignation of the Primary Dental Office from United Concordia’s ConcordiaPLUS network, the Primary Dental Office shall be liable on existing contracts through the end of each contract’s current year in accordance with Section 38.2 - 4507 of the Annotated Code of Virginia. The Primary Dental Office shall be liable for his own torts and not for the torts of any participant or of the agent.

D. Good Faith

1. Both parties enter this Agreement as independent contracting entities in good faith and will strive to adhere to the intent and provisions thereof. All information provided to the Primary Dental Office under this Agreement is proprietary and not to be disclosed to any other party.

2. In the event of a complaint regarding this Agreement, the complaining party agrees to notify the other party in writing, outlining the nature of the complaint.

3. The recipient of a complaint agrees to respond in writing to such complaints within fifteen (15) working days of receipt of the complaint and to act in good faith toward a mutually acceptable solution.

4. These provisions in no way waive or affect the right of either party to terminate this Agreement.

E. Term and Termination; Assignment; Regulatory Approval

This Agreement shall be effective immediately for an initial term of one (1) year and shall continue in effect thereafter from year to year, until terminated by either party according to the following provisions:

1. United Concordia may terminate this Agreement during the initial term or any point thereafter upon written notice if the Primary Dental Office or any dentist of the Primary Dental Office fails to maintain a legally qualified license to practice dentistry or commits unethical or unprofessional acts or if Dentist fails to comply with the terms of this Agreement.
2. After the initial term (1 year), this Agreement may be terminated by either party upon sixty (60) days written notice. The Primary Dental Office will continue to provide services for enrolled Members until they can be transferred to another acceptable Primary Dental Office or for sixty (60) days from United Concordia’s receipt of notice of termination, whichever comes sooner.

3. This Agreement shall be assignable by United Concordia but only to a subsidiary, affiliate, or successor corporation of United Concordia.

4. In the event that United Concordia Companies, Inc., or the appropriate affiliated organization has not been licensed or has not obtained any applicable regulatory approval for the use of this Agreement prior to the execution of this Agreement, this Agreement shall become effective upon such licensing or approval, as applicable. If unable to obtain such licensure or approval after due diligence, United Concordia shall notify the Primary Dental Office and both parties shall be released from any liability under this Agreement; provided however, that if such licensure or approval is obtained upon condition of amendments to this Agreement, such amendments will be provided to the Primary Dental Office.

5. The interpretation of this Agreement is governed by the laws of the Commonwealth of Virginia.

UNITED CONCORDIA COMPANIES, INC.

Date: __________________ By: _________________________________________________
Title:

PROVIDER:

Date: __________________ By: ________________________________________
(Please Print)

Telephone No.: ( )__________
SS No. ________________________
Tax ID No.: __________________
License No.: __________________

Signature: __________________________
Address: __________________________

Form 12-301 VA0696

ConcordiaPLUS
Schedule A

UNITED CONCORDIA COMPANIES, INC.
And Its Affiliated Organizations

United Concordia Companies, Inc.
United Concordia Life and Health Insurance Company
United Concordia Dental Corporation
United Concordia Dental Corporation of Alabama
United Concordia Dental Plans, Inc.
JustDental\textsuperscript{sm} of Delmarva, Inc.
Medical Service Association of Pennsylvania d/b/a Pennsylvania Blue Shield
Schedule B

Capitation Amounts

To obtain current capitation amounts by plan, please visit www.unitedconcordia.com.
Schedule C

Malpractice Insurance Requirements

Each Dentist shall maintain professional liability limits no less than $1,000,000 per occurrence/$3,000,000 aggregate, and shall comply with the provisions of Section A.10 of the Primary Dental Office Agreement.
## Schedule D

**List of Participating Dentists at the Primary Dental Office**

<table>
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<tr>
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* (Name of dentist who executes agreement), has been authorized by me to bind me to the terms and conditions herein. No further action on my part is required to effectuate this authorization. My signature on this page is not required to effectuate this authorization, but rather indicates that I, personally, have had the opportunity to read the attached Agreement and its Exhibits, and that I agree to be bound by them.

**NOTE:**

**Attached is part II of Schedule D - copy of application showing the address and hours of operation**
The Primary Dental Office Agreement with United Concordia Companies, Inc. and its Affiliated Organizations for Capitated Dental Managed Care Programs (the “Agreement”) is amended as set forth below. This Addendum supersedes previous addenda and is effective for Agreements entered into, amended, extended or renewed on or after January 1, 2006.

A. Obligations of the Primary Dental Office

Replace provision A. 5. with the following:

5. May request to “hold” the number of members assigned to their office by providing ninety (90) days written notice to United Concordia. The Primary Dental Office is excluded from any applicable Provider Protection Plans for the period such office is on “hold” (not accepting new members).

Replace provision A. 7. with the following:

2. Will maintain accurate and complete dental records for all Members enrolled in the Plan and will report to United Concordia all covered services provided to Plan Members by the 10th of the month following the end of the quarter in which services are rendered for encounters and 12 months from the date services are rendered for services that involve claims payment.

Add new subsection:

13. Will notify United Concordia within 10 business days of any changes in the status of any credentialing criteria.

B. Obligations of United Concordia and Its Affiliated Organizations

Add new subsections:

United Concordia will, where applicable for those Primary Dental Office relationships that involve claims payment, adhere and comply with the following minimum fair business standards in the processing and payment of claims for dental care services. “Claims” as used in the Agreement and this Addendum shall not include requests for payment of capitation, supplemental capitation, withhold or provider protection plan or similar payments.

a. United Concordia will pay any claim within forty (40) days of receipt except where its payment obligation is not reasonably clear due to the existence of a reasonable basis that is supported by specific information available to the Primary Dental Office that:
1) the claim is not a clean claim, as determined in good faith by United Concordia, based on (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

2) the claim was submitted fraudulently.

United Concordia will maintain a written or electronic record of the date of receipt of a claim and will permit the Primary Dental Office to inspect the record upon request and rely on the record including electronic or facsimile confirmation of receipt of the claim.

b. United Concordia will request electronically or in writing within thirty days after receipt of a claim from the Primary Dental Office, the information and documentation United Concordia believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information, United Concordia will pay the claim in compliance with Title 38.2, Section 3407.15 of the Virginia Code. United Concordia will not refuse to pay a claim for dental care services rendered which are covered benefits if United Concordia failed to notify or attempt to notify the Primary Dental Office of any additional information required within 30 days of receipt of a claim, unless such failure was caused in material part by the Primary Dental Office. United Concordia may retroactively deny payment of such claim unless such action would violate section g. below. United Concordia is not required to pay a claim which is not a clean claim.

c. United Concordia will pay any interest owing or accruing on a claim in accordance with Title 38.2, Sections 38.2-3407.1 or 38.2-4306.1 of the Virginia Code within sixty (60) days of claim payment.

d. United Concordia will establish reasonable policies to permit the Primary Dental Office to: 1) confirm in advance during normal business hours by free telephone or electronic means whether the dental care services to be provided are dentally necessary and a covered benefit and 2) determine United Concordia’s requirements applicable to the Primary Dental Office. These requirements may include (i) pre-certification or authorization of coverage decisions, (ii) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (iii) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (iv) other provider-specific, applicable claims processing and payment matters necessary to meet United Concordia’s requirements, including determining whether a claim is a clean claim. United Concordia routinely, as a matter of policy, bundles or downcodes claims submitted by the Primary Dental Office in accordance with its dental payment policies. The Primary Dental Office may use the following facsimile number, 717-260-7190, to request the specific bundling and downcoding policies United Concordia reasonably expects to apply to the Primary Dental Office’s services on a routine basis as a matter of policy. United Concordia shall provide such policies to the requesting Primary Dental Office within 10 business days following the date United Concordia receives the request.
e. United Concordia will make available within ten (10) business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the Primary Dental Office or to particular dental care services identified by the Primary Dental Office. In the event the provisioning of such policies would violate any applicable copyright law, United Concordia will timely deliver a clear explanation of the policies as applies to the provider and to any dental care services identified by the provider.

f. United Concordia will pay a claim if United Concordia has previously authorized the dental care service or has advised the Primary Dental Office or enrollee in advance that the dental care services are dentally necessary and a covered benefit, unless:

1) The documentation for the claim fails to support the claim as originally authorized; or

2) The refusal is because (i) another payor is responsible for the payment, (ii) the Primary Dental Office has already been paid for the dental care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to United Concordia by the Primary Dental Office, enrollee, or other person not related to United Concordia, or (iv) the person receiving the dental care services was not eligible to receive them on the date of service and United Concordia did not know, and with the exercise of reasonable care could not have known, of the person’s eligibility status.

g. United Concordia will not retroactively deny a previously paid claim unless United Concordia has provided the reason for the retroactive denial and 1) the original claim was submitted fraudulently, 2) the original claim payment was incorrect because the Primary Dental Office was already paid for the dental care services identified on the claim or the dental care services identified on the claim were not delivered by the Primary Dental Office, or 3) not more than 12 months have lapsed since the payment of the original challenged claim. United Concordia will notify a provider at least 30 days in advance of any retroactive denial of a claim.

h. Notwithstanding section g, with respect to provider agreements entered into, amended, extended, or renewed on or after July 1, 2004, United Concordia shall not impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless United Concordia specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

i. United Concordia shall establish in writing its claims payment dispute mechanism and make this mechanism available to Dentist.

j. United Concordia shall permit Dentist and Dentist shall discuss treatment options with members.
k. Will provide a process through which the Primary Dental Office may appeal decisions affecting the condition of their participation based on issues of quality of care or service, except in circumstances where an enrollee’s dental health has been jeopardized.

l. Will upon contracting with an unaffiliated carrier with reimbursement rates or with managed care procedures that differ materially from the terms agreed to by the Primary Dental Office in this Agreement and Addendum, allow the Primary Dental Office to refuse participation with the unaffiliated carrier. The status of the Primary Dental Office as a member of, or as being eligible for, another existing or new provider panel will not be adversely affected by the refusal to participate. Material differences may include economic profiling. Utilization review is not considered a material difference.

m. Will include or attach at the time this Agreement and Addendum is presented to the Primary Dental Office for execution: a) any applicable fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid, and b) all material addenda, schedules and exhibits thereto and any policies applicable to the Primary Dental Office or to the range of dental care services reasonably expected to be delivered by the Primary Dental Office under the Agreement. In the event that the provision of a policy, schedule, statement, exhibit, or addenda would violate any applicable copyright law, United Concordia may instead provide a clear, written explanation as applies to the Primary Dental Office.

E. Terms and Termination; Assignment; Regulatory Approval

Replace provision E.2. with the following:

2. After the initial one year term, the Agreement and this Addendum may be terminated by either party upon ninety (90) days written notice except when the termination is for cause. The Primary Dental Office will continue to provide services for enrolled Members until they can be transferred to another acceptable Primary Dental Office or for ninety (90) days from United Concordia’s receipt of notice of termination, whichever comes sooner.

Add new subsection:

No amendment to this Agreement, any addenda, schedule, exhibit or policy thereto or new addenda, schedule, exhibit or policy applicable to the Primary Dental Office or to the range of dental care services reasonably expected to be delivered by the Primary Dental Office shall be effective as to The Primary Dental Office, unless United Concordia has been provided the Primary Dental Office with the applicable portion of the proposed amendment or proposed new addenda, schedule, exhibit or policy at least sixty (60) calendar days before the effective date. If the Primary Dental Office has not notified United Concordia in writing within thirty (30) calendar days of receipt of the documentation of his/her intention to terminate the Agreement at the earliest date thereafter permitted under this Agreement, such document shall become effective and binding without further action by the Primary Dental Office or United Concordia. In the event that the provision of a policy, schedule, statement, exhibit, or addenda would violate any applicable copyright law, United Concordia may instead provide a clear, written explanation as applies to the Primary Dental Office.
Replace Schedule A:

Schedule A includes the following United Concordia affiliates:

United Concordia Companies, Inc.
United Concordia Dental Corporation of Alabama
United Concordia Dental Plans, Inc.
United Concordia Dental Plans of the Midwest, Inc.
United Concordia Insurance Company
United Concordia Life and Health Insurance Company
SPECIALTY CARE DENTIST AGREEMENT
with United Concordia Companies, Inc. and
Its Affiliated Organizations
for Capitated Dental Managed Care Programs

Under the applicable laws of the State of Maryland, I (we) am (are) (hereinafter "Specialty Care Dentist") duly authorized to engage in the practice of dentistry. In consideration for being registered as a participating Specialty Care Dentist (board certified/board eligible) for the ConcordiaPLUS network of United Concordia Companies, Inc. and its affiliated organizations (hereinafter collectively "United Concordia"), I (we) do hereby agree to all provisions of this Specialty Care Dentist Agreement (the "Agreement") as follows:

A. Obligations of the Specialty Care Dentist

The Specialty Care Dentist:

1. Will provide dental services within my (our) specialty covered under each Group's benefit plan, as defined in the applicable Certificates of Coverage, master contracts, and administrative agreements to those Members who are enrolled in a United Concordia dental program (hereinafter "Plan"). The Specialty Care Dentist agrees to listing of the office in Plan directories of participating dental providers.

2. Agrees that the Maximum Allowable Charge (MAC) schedule amounts will constitute payment in full. This amount will be the combination of the patient’s applicable deductibles, copayment amounts and any amount due from United Concordia to achieve the MAC amount set forth in Schedule A. Members Copayment schedules are attached as Schedule B. The Specialty Care Dentist agrees that under no circumstances, including non-payment by United Concordia, shall the Specialty Care Dentist seek payment from an Enrollee for services rendered under this Agreement for other than a Copayment listed on the Member Copayment Schedule. The Specialty Care Dentist further agrees that this provision shall survive the termination of this Agreement regardless of the cause of the termination.

3. Will accept as patients all Members who are referred by a United Concordia participating Dentist and schedule appointments for all Members using the same standards applicable to all other patients and without discrimination on the basis of sex, race, nationality, religion, health, insurance status, economic status, or hours of operation. The Specialty Care Dentist will notify United Concordia of any change in hours of operation, location or change of ownership.

4. Shall be responsible, at all times, for maintaining emergency coverage, provided in accordance with the guidelines of the American Dental Association ("ADA") or applicable law.

5. Will maintain accurate and complete dental records for all Members enrolled in the Plan and will report to United Concordia all covered services provided to Plan Members within forty-five (45) days following the date the services were rendered using a standard ADA format or other format approved by United Concordia and consistent with the Group’s Agreement.
6. Will provide information to United Concordia relative to Members who may be entitled to receive benefits under any other group plan for Dental Services covered by this Agreement or under any governmental program for which any periodic payment is made by or for the Member. In addition, the Specialty Care Dentist agrees to abide by the Coordination of Benefits provision delineated in the applicable Certificates of Coverage and Specialty Care Dental Office Manual.

7. Will participate fully in the Quality Review Program and Member Grievance Process, as amended from time to time by United Concordia, and will comply with any reasonable request for a quality assessment review and provide timely responses and documentation relative to any Member grievance upon notification by United Concordia.

8. Will abide by the claims and professional policies as amended from time to time by United Concordia. Such policies include but are not limited to the fragmenting of procedures which should be integral to a more comprehensive procedure. Specialty Care Dentist agrees not to charge or collect from any Member amounts for fragmented procedures determined to be integral or for any other procedure which is determined not to be eligible for a separate charge.

9. Will have/obtain professional liability (malpractice) insurance coverage in the amount specified on Schedule C (or such greater amount as may be required by law) from a carrier authorized to do business in the state of the Specialty Care Dentist's practice and shall maintain such insurance throughout the term of this Agreement for all providers in the office covered under this Agreement. The Specialty Care Dentist will provide information necessary for provider credentialing on any and all dentists providing services under this Agreement on a permanent, part-time or substitution basis, as well as timely notification to United Concordia of any change to the dentist(s) credentials or license to practice.

10. Warrants and represents that the party executing this Agreement on behalf of the Specialty Care Dentist has authority to do so and to bind the Specialty Care Dentist and all individual Specialty Care Dentists practicing at the specialty facility to the terms and conditions herein regardless of whether any one or more of the individual specialty care dentists listed on Schedule D, attached hereto, signs this Agreement or the attached Schedule D. The Specialty Care Dentist shall update this Schedule within fifteen (15) days of any change.

11. Will not during the term of this Agreement and for a period of two years after termination of this Agreement directly or indirectly engage in the solicitation of Members to disenroll and/or join any other dental benefit program, particularly any program in which the Specialty Care Dentist(s) has a financial interest or receives a monetary or material incentive, and acknowledges that this is a reasonable and necessary protection to United Concordia and that any violation of this provision would result in irreparable damage to United Concordia. In the event of a violation of this provision, United Concordia shall be entitled to any legal or equitable remedy to protect its interest.

13. Shall notify each Member of the termination of the Member's Group Agreement if the Member visits the Specialty Care Dentist when the Specialty Care Dentist is aware that the Group Agreement has terminated.

Under these circumstances, the Specialty Care Dentist shall inform the Member of the charge for any scheduled dental services before performing the dental services.
B. Obligations of United Concordia and Its Affiliated Organizations

United Concordia:

1. Will provide to the Specialty Care Dentist a MAC Schedule and Member Copayment Schedule (Schedules A and B, respectively) for each plan. MAC Schedule and patient copayments will be reviewed periodically.

2. Will provide the Specialty Care Dentist with patient encounter/claim forms upon request or electronic access to report all services provided to capitated Members.

3. Will furnish the Specialty Care Dentist with resource materials: e.g., a Specialty Care Dental Office Manual setting out the procedures of United Concordia and will provide and update group benefit and copayment reports.

4. Will establish and administer a Quality Review Program utilizing a continuous improvement model. A copy of the Quality Review Program will be furnished to the Specialty Care Dentist.

5. Will provide a MAC Schedule as described in Schedule A, and as may be amended by United Concordia.

6. Will establish a grievance committee for the investigation and resolution of member complaints relative to care administered by a Specialty Care Dentist.

C. Relationship of the Parties

United Concordia and the Specialty Care Dentist:

1. United Concordia shall not be liable for injuries or damages resulting from acts or omissions of any Specialty Care Dentist, employee, or other person furnishing services or supplies to the Member.

2. United Concordia shall not hold a Specialty Care Dentist responsible for any acts or obligations of any other Specialty Care Dentist or any other person(s) furnishing dental services or supplies to the Member.

3. None of the provisions of this Agreement are intended to create, nor shall be deemed to create, any relationship between the parties other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be considered to be the agent, employer, employee or representative of the other.

4. United Concordia agrees to defend and hold harmless the Specialty Care Dentist in connection with any claim or cause of action which is asserted against the Specialty Care Dentist based upon the
sole fact of its participation in the Plan. If the claim or cause of action includes facts which could have been alleged irrespective of the Specialty Care Dentist's participation in the Plan, United Concordia will have no obligation to defend and hold harmless the Specialty Care Dentist in connection with those allegations. Furthermore, in no event shall United Concordia have any obligation to defend and hold harmless the Specialty Care Dentist in connection with injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of the Specialty Care Dentist, in the course of rendering services to Members enrolled under the Plan or to any other patient.

5. The Specialty Care Dentist agrees that in no event, including, but not limited to non-payment by United Concordia, or insolvency or breach of this Agreement by United Concordia, shall the Specialty Care Dentist bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or person(s) other than United Concordia acting on the Member's behalf for covered services. This provision shall not prohibit collection of coinsurances or copayments in accordance with the terms of the Certificates of Coverage, master contracts, and administrative agreements.

The Specialty Care Dentist further agrees that, (1) the hold harmless provision herein shall survive the termination of this Agreement, regardless of the cause giving rise to such termination; and that, (2) this hold harmless provision supersedes any oral or written contractual agreement now existing or hereafter entered into between the Specialty Care Dentist and the Member or person(s) acting on his/her behalf.

D. Good Faith

1. Both parties enter this Agreement as independent contracting entities in good faith and will strive to adhere to the intent and provisions thereof. All information provided to the Specialty Care Dentist under this Agreement is proprietary and not to be disclosed to any other party.

2. In the event of a complaint regarding this Agreement, the complaining party agrees to notify the other party in writing, outlining the nature of the complaint.

3. The recipient of a complaint agrees to respond in writing to such complaints within fifteen (15) working days of receipt of the complaint and to act in good faith toward a mutually acceptable solution.

4. These provisions in no way waive or affect the right of either party to terminate this Agreement.

E. Term and Termination; Assignment; Regulatory Approval

This Agreement shall be effective immediately for an initial term of one (1) year and shall continue in effect thereafter from year to year, until terminated by either party according to the following provisions:
1. United Concordia may terminate this Agreement during the initial term or any point thereafter upon written notice if the Specialty Care Dentist or any employee of the Specialty Care Dentist fails to maintain a legally qualified license to practice dentistry or commits unethical or unprofessional acts or if Dentist fails to comply with the terms of this Agreement.

2. After the initial term of one (1) year, this Agreement may be terminated by either party upon ninety (90) days written notice for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status by the Specialty Care Dentist. The Specialty Care Dentist may not terminate this Agreement during the initial term unless the Specialty Care Dentist becomes unavailable during the initial term for reasons beyond the control of United Concordia or the Specialty Care Dentist, as set forth in the applicable Certificate of Coverage.

3. For a period of at least ninety (90) days from the date of the notice of a Specialty Care Dentist’s termination from the Plan for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status, the Specialty Care Dentist shall render dental services to any of the Plan’s Enrollees who:
   a. Were receiving health care services from the Specialty Care Dentist prior to the notice of termination; and
   b. Request, after receiving notice of the Specialty Care Dentist’s termination, to continue receiving dental services from the Specialty Care Dentist.

4. This Agreement shall be assignable by United Concordia but only to a subsidiary, affiliate, or successor corporation of United Concordia.

5. In the event that United Concordia Companies, Inc. or the appropriate affiliated organization has not been licensed or has not obtained any applicable regulatory approval for the use of this Agreement prior to the execution of this Agreement, this Agreement shall become effective upon such licensing or approval, as applicable. If unable to obtain such licensure or approval after due diligence, United Concordia shall notify the Specialty Care Dentist and both parties shall be released from any liability under this Agreement; provided however, that if such licensure or approval is obtained upon condition of amendments to this Agreement, such amendments will be provided to the Specialty Care Dentist.

6. The interpretation of this Agreement is governed by the laws of the State of Maryland.
UNITED CONCORDIA COMPANIES, INC.

Date: __________________

By: _______________________
(Please Print)

Signature: __________________

Address: __________________

Telephone No.: ( ) __________

SS No. ____________________

Tax ID No.: __________________

License No.: __________________

PROVIDER:
Maximum Allowable Charge (MAC) Schedules are available upon request by calling our Interactive Voice Response (IVR) system at (866) 357-3304 or by utilizing My Patients’ Benefits at www.unitedconcordia.com.
Schedule B

Member Copayment Schedule

Copayment Schedules are available upon request by calling our Interactive Voice Response (IVR) system at (866) 357-3304 or by utilizing My Patients’ Benefits at www.unitedconcordia.com. Copayment schedules are also mailed directly to offices as updates are made.
Malpractice Insurance Requirements

Each Dentist shall maintain professional liability limits no less than $1,000,000 per occurrence/$3,000,000 aggregate, and shall comply with the provisions of Section A.9 of the Specialty Care Dentist Agreement.
### Schedule D

**List of Participating Dentists at the Specialty Care Dentist Office**

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* (Name of dentist who executes agreement), has been authorized by me to bind me to the terms and conditions herein. No further action on my part is required to effectuate this authorization. My signature on this page is not required to effectuate this authorization, but rather indicates that I, personally, have had the opportunity to read the attached Agreement and its Exhibits, and that I agree to be bound by them.

**NOTE:**

**Attached is part II of Schedule D - copy of application showing the address and hours of operation**
ADDENDUM TO THE
SPECIALTY CARE DENTIST AGREEMENT
With United Concordia Companies, Inc. and
Its Affiliated Organizations
For Capitated Dental Managed Care Programs

The Specialty Care Dentist Agreement With United Concordia Companies, Inc. and its Affiliated Organizations for Capitated Dental Managed Care Programs (the “Agreement”) is hereby amended as follows:

A. Obligations of the Specialty Care Dentist

Replace provision A. 5. with the following:

5. Will maintain accurate and complete dental records for all Members enrolled in the Plan and will report to United Concordia all covered services provided to Plan Members within one hundred eighty (180) days following the date the services were rendered using a standard ADA format or other format approved by United Concordia and consistent with the Group’s Agreement.
SPECIALTY CARE DENTIST AGREEMENT
with United Concordia Companies, Inc. and
Its Affiliated Organizations
for Capitated Dental Managed Care Programs

Under the applicable laws of the Commonwealth of Virginia, I (we) am (are) (hereinafter "Specialty Care Dentist") duly authorized to engage in the practice of dentistry. In consideration for being registered as a participating Specialty Care Dentist (board certified/board eligible) for the ConcordiaPLUS network of United Concordia Companies, Inc. and its affiliated organizations identified in Schedule A, as supplemented from time to time (hereinafter collectively "United Concordia"), I (we) do hereby agree to all provisions of this Specialty Care Dentist Agreement (the "Agreement") as follows:

A. Obligations of the Specialty Care Dentist

The Specialty Care Dentist:

1. Will provide dental services within my (our) specialty covered under each Group's benefit plan, as defined in the applicable Certificates of Coverage, master contracts, and administrative agreements to those Members who are enrolled in a United Concordia dental program (hereinafter "Plan"). The Specialty Care Dentist agrees to listing of the office in Plan directories of participating dental providers.

2. Agrees that the Maximum Allowable Charge (MAC) schedule amounts will constitute payment in full. This amount will be the combination of the patient’s copayment amount and any amount due from United Concordia to achieve the MAC amount set forth in Schedule B. Members Copayment schedules are in Schedule C.

3. Will accept as patients all Members who are referred by United Concordia's participating Dentists and schedule appointments for all Members using the same standards applicable to all other patients and without discrimination on the basis of sex, race, nationality, religion, health, insurance status, economic status, or hours of operation. The Specialty Care Dentist will notify United Concordia of any change in hours of operation, location or change of ownership.

4. Shall be responsible, at all times, for maintaining emergency coverage, provided in accordance with the guidelines of the American Dental Association ("ADA") or applicable law.

5. Will maintain accurate and complete dental records for all Members enrolled in the Plan and will report to United Concordia all covered services provided to Plan Members within forty-five (45) days following the date the services were rendered using a standard ADA format or other format approved by United Concordia.
6. Will provide information to United Concordia relative to Members who may be entitled to receive benefits under any other group plan for Dental Services covered by this Agreement or under any governmental program for which any periodic payment is made by or for the Member. In addition, the Specialty Care Dentist agrees to abide by the Coordination of Benefits provision delineated in the applicable Certificates of Coverage and Specialty Care Dental Office Manual.

7. Will participate fully in the Quality Review Program and Member Grievance Process, as amended from time to time by United Concordia, and will comply with any reasonable request for a quality assessment review and provide timely responses and documentation relative to any Member grievance upon notification by United Concordia.

8. Will abide by the claims and professional policies as amended from time to time by United Concordia. Such policies include but are not limited to the fragmenting of procedures which should be integral to a more comprehensive procedure. Specialty Care Dentist agrees not to charge or collect from any Member amounts for fragmented procedures determined to be integral or for any other procedure which is determined not to be eligible for a separate charge.

9. Will have/obtain professional liability (malpractice) insurance coverage in the amount specified on Schedule D (or such greater amount as may be required by law) from a carrier authorized to do business in the state of the Specialty Care Dentist's practice and shall maintain such insurance throughout the term of this Agreement for all providers in the office covered under this Agreement. The Specialty Care Dentist will provide information necessary for provider credentialing on any and all dentists providing services under this Agreement on a permanent, part-time or substitution basis, as well as timely notification to United Concordia of any change to the dentist(s) credentials or license to practice.

10. Warrants and represents that the party executing this Agreement on behalf of the Specialty Care Dentist has authority to do so and to bind the Specialty Care Dentist and all individual Specialty Care Dentists practicing at the specialty facility to the terms and conditions herein regardless of whether any one or more of the individual specialty care dentists listed on Schedule E, attached hereto, signs this Agreement or the attached Schedule. The Specialty Care Dentist shall update this Schedule within fifteen (15) days of any change.

11. Will not during the term of this Agreement and for a period of two years after termination of this Agreement directly or indirectly engage in the solicitation of Members to disenroll and/or join any other dental benefit program, particularly any program in which the Specialty Care Dentist(s) has a financial interest or receives a monetary or material incentive, and acknowledges that this is a reasonable and necessary protection to United Concordia and that any violation of this provision would result in irreparable damage to United Concordia. In the event of a violation of this provision, United Concordia shall be entitled to any legal or equitable remedy to protect its interest.
B. Obligations of United Concordia and Its Affiliated Organizations

United Concordia:

1. Will provide to the Specialty Care Dentist a MAC Schedule and Member Copayment Schedule (Schedule B and C, respectively) for each plan. Maximum Allowance Schedules and patient copayments will be reviewed periodically.

2. Will provide the Specialty Care Dentist with patient encounter/claim forms or electronic access to report all services provided to capitated Members.

3. Will furnish the Specialty Care Dentist with resource materials: e.g., a Specialty Care Dental Office Manual setting out the procedures of United Concordia and will provide and update group benefit and copayment reports.

4. Will establish and administer a Quality Review Program utilizing a continuous improvement model. A copy of the Quality Review Program will be furnished to the Specialty Care Dentist.

5. Will provide a MAC Schedule as described in Schedule B, and as may be amended by United Concordia.

6. Will establish a grievance committee for the investigation and resolution of member complaints relative to care administered by a Specialty Care Dentist.

C. Relationship of the Parties

United Concordia and the Specialty Care Dentist:

1. United Concordia shall not be liable for injuries or damages resulting from acts or omissions of any Specialty Care Dentist, employee, or other person furnishing services or supplies to the Member.

2. United Concordia shall not hold a Specialty Care Dentist responsible for any acts or obligations of any other Specialty Care Dentist or any other person(s) furnishing dental services or supplies to the Member.

3. None of the provisions of this Agreement are intended to create, nor shall be deemed to create, any relationship between the parties other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be considered to be the agent, employer, employee or representative of the other.
4. United Concordia agrees to defend and hold harmless the Specialty Care Dentist in connection with any claim or cause of action which is asserted against the Specialty Care Dentist based upon the sole fact of its participation in the Plan. If the claim or cause of action includes facts which could have been alleged irrespective of the Specialty Care Dentist's participation in the Plan, United Concordia will have no obligation to defend and hold harmless the Specialty Care Dentist in connection with those allegations. Furthermore, in no event shall United Concordia have any obligation to defend and hold harmless the Specialty Care Dentist in connection with injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of the Specialty Care Dentist, in the course of rendering services to Members enrolled under the Plan or to any other patient.

5. The Specialty Care Dentist agrees that in no event, including, but not limited to non-payment by United Concordia, or any health maintenance organization (“the health maintenance organization”) licensed by and doing business in the Commonwealth of Virginia which is authorized to sell a JustDental or United Concordia product; or United Concordia’s or the health maintenance organization’s insolvency or breach of this Agreement by United Concordia, shall the Specialty Care Dentist bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or person(s) other than United Concordia acting on the Member's behalf or the health maintenance organization for covered services. This provision shall not prohibit collection of coinsurances or copayments in accordance with the terms of the Certificates of Coverage, master contracts, and administrative agreements.

   The Specialty Care Dentist further agrees that, (1) the hold harmless provision herein shall survive the termination of this Agreement, regardless of the cause giving rise to such termination; and that, (2) this hold harmless provision supersedes any oral or written contractual agreement now existing or hereafter entered into between the Specialty Care Dentist and the Member or person(s) acting on his/her behalf.

   Any modifications, additions, or deletions to the provisions of this hold harmless clause shall become effective on a date no earlier than fifteen (15) days after the Commonwealth of Virginia State Corporation Commission Bureau of Insurance has received written notice of such proposed changes.

6. Pursuant to Section 38.2 - 4505 of the Code of Virginia, all participating Virginia Specialty Care Dentists in United Concordia’s ConcordiaPLUS network shall be jointly and severally liable on all Virginia contracts made for the purpose of United Concordia by United Concordia as agent for them. In the event of the resignation of the Specialty Care Dentist from United Concordia’s ConcordiaPLUS network, the Specialty Care Dentist shall be liable on existing contracts through the end of each contract’s current year in accordance with Section 38.2 - 4507 of the Annotated Code of Virginia. The Specialty Care Dentist shall be liable for his own torts and not for the torts of any participant or of the agent.
D. **Good Faith**

1. Both parties enter this Agreement as independent contracting entities in good faith and will strive to adhere to the intent and provisions thereof. All information provided to the Specialty Care Dentist under this Agreement is proprietary and not to be disclosed to any other party.

2. In the event of a complaint regarding this Agreement, the complaining party agrees to notify the other party in writing, outlining the nature of the complaint.

3. The recipient of a complaint agrees to respond in writing to such complaints within fifteen (15) working days of receipt of the complaint and to act in good faith toward a mutually acceptable solution.

4. These provisions in no way waive or affect the right of either party to terminate this Agreement.

E. **Term and Termination; Assignment; Regulatory Approval**

This Agreement shall be effective immediately for an initial term of one (1) year and shall continue in effect thereafter from year to year, until terminated by either party according to the following provisions:

1. United Concordia may terminate this Agreement during the initial term or any point thereafter upon written notice if the Specialty Care Dentist or any employee of the Specialty Care Dentist fails to maintain a legally qualified license to practice dentistry or commits unethical or unprofessional acts or if Dentist fails to comply with the terms of this Agreement.

2. After the initial term (1 year), this Agreement may be terminated by either party upon sixty (60) days written notice.

3. This Agreement shall be assignable by United Concordia but only to a subsidiary, affiliate, or successor corporation of United Concordia.

4. In the event that United Concordia Companies, Inc. or the appropriate affiliated organization has not been licensed or has not obtained any applicable regulatory approval for the use of this Agreement prior to the execution of this Agreement, this Agreement shall become effective upon such licensing or approval, as applicable. If unable to obtain such licensure or approval after due diligence, United Concordia shall notify the Specialty Care Dentist and both parties shall be released from any liability under this Agreement; provided however, that if such licensure or approval is obtained upon condition of amendments to this Agreement, such amendments will be provided to the Specialty Care Dentist.
5. The interpretation of this Agreement is governed by the laws of the Commonwealth of Virginia.

UNITED CONCORDIA COMPANIES, INC.

Date: __________________________

By: ____________________________
Title: __________________________

PROVIDER:

Date: __________________________

By: ____________________________
(Please Print)

Telephone No.: ( )________________
SS No.: _________________________
Tax ID No.: ______________________
License No.: _____________________

Signature: _______________________
Address: ________________________
Schedule A

UNITED CONCORDIA COMPANIES, INC.
And Its Affiliated Organizations

United Concordia Companies, Inc.
United Concordia Life and Health Insurance Company
United Concordia Dental Corporation
United Concordia Dental Corporation of Alabama
United Concordia Dental Plans, Inc.
JustDental<sup>SM</sup> of Delmarva, Inc.
Medical Service Association of Pennsylvania d/b/a Pennsylvania Blue Shield
Schedule B

Maximum Allowable Charge Schedule

Maximum Allowable Charge (MAC) Schedules are available upon request by calling our Interactive Voice Response (IVR) system at (866) 357-3304 or by utilizing My Patients’ Benefits at www.unitedconcordia.com.
Schedule C

Member Copayment Schedule

Copayment Schedules are available upon request by calling our Interactive Voice Response (IVR) system at (866) 357-3304 or by utilizing My Patients’ Benefits at www.unitedconcordia.com. Copayment schedules are also mailed directly to offices as updates are made.
Schedule D

Malpractice Insurance Requirements

Each Dentist shall maintain professional liability limits no less than $1,000,000 per occurrence/$3,000,000 aggregate, and shall comply with the provisions of Section A.9 of the Specialty Care Dentist Agreement.
## Schedule E

List of Participating Dentists at the Specialty Care Dentist Office

<table>
<thead>
<tr>
<th>Provider</th>
<th>License #</th>
<th>S.S. No.</th>
<th>Tax I.D. #</th>
<th>Specialty</th>
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</table>

* (Name of dentist who executes agreement), has been authorized by me to bind me to the terms and conditions herein. No further action on my part is required to effectuate this authorization. My signature on this page is not required to effectuate this authorization, but rather indicates that I, personally, have had the opportunity to read the attached Agreement and its Exhibits, and that I agree to be bound by them.

**NOTE:**

** Attached is part II of Schedule E - copy of application showing the address and hours of operation
This Specialty Care Dentist Agreement with United Concordia Companies, Inc. and Its Affiliated Organizations For Capitated Dental Managed Care Programs (the “Agreement”) is amended as set forth below. This Addendum supersedes previous addenda and is effective for Agreements entered into, amended, extended or renewed on or after January 1, 2006.

A. Obligations of the Specialty Care Dentist

Replace provision A. 5. with the following:

5. Will maintain accurate and complete dental records for all Members enrolled in the Plan and will report to United Concordia all covered services provided to Plan Members within 12 months from the date services are rendered for services that involve claim payments.

New subsection:

12. Will notify United Concordia within 10 business days of any changes in the status of any credentialing criteria.

B. Obligations of United Concordia and Its Affiliated Organizations

Add New subsections:

Will, where applicable for those Specialty Care Dentist relationships that involve claims payment, adhere and comply with the following fair business standards in the processing and payment of claims for dental care services. “Claims” as used in the Agreement and this Addendum shall not include requests for payment of capitation, supplemental capitation, withhold or provider protection plan or similar payments.

United Concordia:

a. Will pay any claim within forty (40) days of receipt except where its payment obligation is not reasonably clear due to the existence of a reasonable basis that is supported by specific information available to the Specialty Care Dentist that:

1) the claim is not a clean claim, as determined in good faith by United Concordia, based on (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

2) the claim was submitted fraudulently.
United Concordia will maintain a written or electronic record of the date of receipt of a claim and will permit the Specialty Care Dentist to inspect the record upon request and rely on the record including electronic or facsimile confirmation of receipt of the claim.

b. Will request electronically or in writing within thirty days after receipt of a claim from the Specialty Care Dentist, the information and documentation United Concordia believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information, United Concordia will pay the claim in compliance with Title 38.2, Section 3407.15 of the Virginia Code. United Concordia will not refuse to pay a claim for dental care services rendered which are covered benefits if United Concordia failed to notify or attempt to notify the Specialty Care Dentist of any additional information required within 30 days of receipt of a claim, unless such failure was caused in material part by the Specialty Care Dentist. United Concordia may retroactively deny payment of such claim unless such action would violate section g. below. United Concordia is not required to pay a claim which is not a clean claim.

c. Will pay any interest owing or accruing on a claim in accordance with Title 38.2, Sections 38.2-3407.1 or 38.2-4306.1 of the Virginia Code within sixty (60) days of claim payment.

d. Will establish reasonable policies to permit the Specialty Care Dentist to: 1) confirm in advance during normal business hours by free telephone or electronic means whether the dental care services to be provided are dentally necessary and a covered benefit and 2) determine United Concordia’s requirements applicable to the Specialty Care Dental Office. These requirements may include (i) pre-certification or authorization of coverage decisions, (ii) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (iii) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (iv) other provider-specific, applicable claims processing and payment matters necessary to meet United Concordia’s requirements, including determining whether a claim is a clean claim. United Concordia routinely, as a matter of policy, bundles or downcodes claims submitted by the Specialty Care Dentist in accordance with its dental payment policies. The Specialty Care Dentist may use the following facsimile number, 717-260-7190, to request the specific bundling and downcoding policies United Concordia reasonably expects to apply to the Specialty Care Dentist’s services on a routine basis as a matter of policy. United Concordia shall provide such policies to the requesting Specialty Care Dentist within 10 business days following the date United Concordia receives the request.

e. Will make available within ten (10) business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the Specialty Care Dentist or to particular dental care services identified by the Specialty Care Dentist. In the event the provisioning of such policies would violate any applicable copyright law, United Concordia will timely deliver a clear explanation of the policies as applies to the provider and to any dental care services identified by the provider.
f. Will pay a claim if United Concordia has previously authorized the dental care service or has advised the Specialty Care Dentist or enrollee in advance that the dental care services are dentally necessary and a covered benefit, unless:

1) The documentation for the claim fails to support the claim as originally authorized; or

2) The refusal is because (i) another payor is responsible for the payment, (ii) the Specialty Care Dentist has already been paid for the dental care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to United Concordia by the Specialty Care Dentist, enrollee, or other person not related to United Concordia, or (iv) the person receiving the dental care services was not eligible to receive them on the date of service and United Concordia did not know, and with the exercise of reasonable care could not have known, of the person’s eligibility status.

g. Will not retroactively deny a previously paid claim unless United Concordia has provided the reason for the retroactive denial and 1) the original claim was submitted fraudulently, 2) the original claim payment was incorrect because the Specialty Care Dentist was already paid for the dental care services identified on the claim or the dental care services identified on the claim were not delivered by the Specialty Care Dentist, or 3) not more than 12 months have lapsed since the payment of the original challenged claim. United Concordia will notify a provider at least 30 days in advance of any retroactive denial of a claim.

h. Notwithstanding subdivision g, with respect to provider agreements entered into, amended, extended, or renewed on or after July 1, 2004, United Concordia shall not impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless United Concordia specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

i. Will establish in writing its claims payment dispute mechanism and make this mechanism available to Dentist.

j. Will permit Dentist and Dentist shall discuss treatment options with members.

k. Will include or attach at the time this Agreement and Addendum is presented to the Specialty Care Dentist for execution: a) any applicable fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid, and b) all material addenda, schedules and exhibits thereto and any policies applicable to the Specialty Care Dentist or to the range of dental care services reasonably expected to be delivered by the Specialty Care Dentist under the Agreement. In the event that the provision of a policy, schedule, statement, exhibit, or addenda would violate any applicable copyright law, United Concordia may instead provide a clear, written explanation as applies to the provider.

l. Will provide a process through which the Specialty Care Dentist may appeal decisions affecting the condition of their participation based on issues of quality of
care or service, except in circumstances where an enrollee’s dental health has been jeopardized.

m. Will upon contracting with an unaffiliated carrier with reimbursement rates or with managed care procedures that differ materially from the terms agreed to by the Specialty Care Dentist in this Agreement and Addendum, allow the Specialty Care Dentist to refuse participation with the unaffiliated carrier. The status of the Specialty Care Dentist as a member of, or as being eligible for, another existing or new provider panel will not be adversely affected by the refusal to participate. Material differences may include economic profiling. Utilization review is not considered a material difference.

E. Terms and Termination; Assignment; Regulatory Approval

Replace provision E.2. with the following:

2. After the initial one year term, the Agreement and this Addendum may be terminated by either party upon ninety (90) days written notice except when the termination is for cause. The Specialty Care Dentist will continue to provide services for enrolled Members until they can be transferred to another acceptable Specialty Care Dentist or for ninety (90) days from United Concordia’s receipt of notice of termination, whichever comes sooner.

Add new subsection:

No amendment to this Agreement, any addenda, schedule, exhibit or policy thereto or new addenda, schedule, exhibit or policy applicable to the Primary Dental Office or to the range of dental care services reasonably expected to be delivered by the Primary Dental Office shall be effective as to The Primary Dental Office, unless United Concordia has been provided the Primary Dental Office with the applicable portion of the proposed amendment or proposed new addenda, schedule, exhibit or policy at least sixty (60) calendar days before the effective date. If the Primary Dental Office has not notified United Concordia in writing within thirty (30) calendar days of receipt of the documentation of his/her intention to terminate the Agreement at the earliest date thereafter permitted under this Agreement, such document shall become effective and binding without further action by the Primary Dental Office or United Concordia. In the event that the provision of a policy, schedule, statement, exhibit, or addenda would violate any applicable copyright law, United Concordia may instead provide a clear, written explanation as applies to the Primary Dental Office. In the event that the provision of a policy, schedule, statement, exhibit, or addenda required above would violate any applicable copyright law, United Concordia may instead provide a clear, written explanation as applies to the provider.

Replace Schedule A:

Schedule A includes the following United Concordia affiliates:

United Concordia Companies, Inc.
United Concordia Dental Corporation of Alabama
United Concordia Dental Plans, Inc.
United Concordia Dental Plans of the Midwest, Inc.
United Concordia Insurance Company
United Concordia Life and Health Insurance Company
# PRACTICE APPLICATION

## I. PRACTICE INFORMATION

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<th>Site Name</th>
<th>Practice Type:</th>
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<td>□ Multi-Disciplinary</td>
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Federal EIN/TIN: ____________________________

## II. PRACTICE STAFFING

Please indicate the names of all Dentists practicing in this site:

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<th>Social Security #</th>
<th>First Name</th>
<th>Last Name</th>
<th>Specialty</th>
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Provider Treats HI Managed Care Patients

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## III. PATIENT MANAGEMENT

Please indicate all languages spoken for which the dentist(s) or office staff are proficient in the dental service environment

- [ ] English
- [ ] Chinese
- [ ] Vietnamese
- [ ] Farsi
- [ ] Spanish
- [ ] Tagalog
- [ ] Korean
- [ ] Hindi
- [ ] Others (specify) ____________________________

Please indicate number of new patients per month the Practice can accept:

______________________

Please indicate how many days a new patient must wait for an appointment:

______________________

Please indicate how many days an existing patient must wait for an appointment:

______________________

Are emergency services available 24 hours per day, 365 days per year?  

- [ ] Yes  
- [ ] No

If yes, please indicate type:

- [ ] Coverage By Associate
- [ ] Answering Machine w/Pager
- [ ] Emergency Number
- [ ] Answering Service
- [ ] Cell Phone w/Pager
- [ ] Call Forwarding

Please indicate method used in recalling patients on a regular basis:

- [ ] Letter
- [ ] Postcard
- [ ] Pre-Appointed
- [ ] Telephone Manual
- [ ] Telephone Automatic
- [ ] None
I. EQUIPMENT MANAGEMENT

<table>
<thead>
<tr>
<th>Is the office equipped with:</th>
<th>☐ X-Ray Units</th>
<th>☐ Nitrous Oxide</th>
<th>☐ Portable Oxygen</th>
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</thead>
</table>

Are emergency services available 24 hours per day, 365 days per year?  ☐ Yes ☐ No

Does radiation equipment meet state inspection/safety requirements?  ☐ Yes ☐ No

*Are X-Ray units currently certified?  ☐ Yes ☐ No

If yes, indicate:

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<tr>
<th>Certification #</th>
<th>Expiration</th>
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*Texas, include both copy of radiographic machine state registration certificate.

V. PRACTICE ATTESTATION

I attest to United Concordia that the information contained in the attached application is true and complete to the best of my knowledge. I agree to inform United Concordia promptly if any material change in such information occurs, whether before or after my entering into an agreement with United Concordia, Inc. for the provision of dental services.

I understand that omissions, misstatements, or failure to comply with the previous statement may be grounds for rejection or termination for cause.

Further, I understand that my application for participation in United Concordia Companies, Inc. dental plans may require a thorough evaluation of my practice, including a consultant review of patient care, as well as review of information pertaining to the items addressed in this application. I hereby authorize release of all such information and understand that it will be reviewed in strict confidence to the degree permitted by law.

________________________________________________________________________
Signature of Principal Dentist

__/__/___
Date
## SECTION 1 - Patient Information

<table>
<thead>
<tr>
<th>Name of Patient</th>
<th>Patient’s Phone Number</th>
<th>Plan # or Group #</th>
<th>Subscriber’s ID #</th>
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</table>

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<tr>
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<th>Sex (Check One): M F</th>
<th>Relationship (Check One): Self Spouse Dep Handicapped</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Is Patient Covered by Another Dental Plan?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Birth:</th>
<th>Social Security #: A n y</th>
<th>Date:</th>
<th>Date of Referral: (referral Expires in 60 days)</th>
</tr>
</thead>
</table>

## SECTION 2 - Referral Information

<table>
<thead>
<tr>
<th>Referral Date:</th>
<th>Referring Dentist Name:</th>
<th>Referring Dentist Address:</th>
<th>Referring Dentist City:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone:</th>
<th>Prov. #:NPI:</th>
<th>SS# or TIN:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Services requested:</th>
<th>This section must be completed for periodontal referrals</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Prophylaxis date(s):</th>
<th>Root planing/scaling/indicate quadrant and date(s):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Root planing or perio maintenance follow-up date(s):</th>
<th></th>
</tr>
</thead>
</table>

## SECTION 3 - Appointment Information/To be completed by Specialist

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>Surface</th>
<th>Procedures Performed</th>
<th>Date of Service</th>
<th>ADA Code</th>
<th>Fee Charged</th>
</tr>
</thead>
</table>

If procedure(s) other than those requested on this referral are necessary, you MUST contact the referring office for approval.

### Specific protocol and conditions exist for specialty referral coverage. Please consult your provider manual for further information.

I hereby certify that the services listed above have been performed and payment is therefore due.

**Dentist Signature**

**Date**

---

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

1. Any person who knowingly, and with intent to defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.
2. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
3. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
4. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
5. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
6. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
7. Any other person who knowingly makes a false statement in a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
8. Any person who willfully files a statement of claim containing any false, incomplete or deceptive statement may have violated the state law.  

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Maryland Uniform Dental Consultation Referral Form

<table>
<thead>
<tr>
<th>Date of Referral:</th>
<th>Carrier Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Information:</th>
<th>Carrier Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: (Last, First, MI)</td>
<td>Name:</td>
</tr>
<tr>
<td>Date of Birth (MM/DD/YY):</td>
<td>Address:</td>
</tr>
<tr>
<td>Member #:</td>
<td>Phone Number: ( )</td>
</tr>
<tr>
<td>Site #:</td>
<td>Facsimile/Data #: ( )</td>
</tr>
</tbody>
</table>

**Primary or Requesting Dentist**

<table>
<thead>
<tr>
<th>Name (Last, First, MI):</th>
<th>Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution/Group Name:</td>
<td>Provider ID #: 1</td>
</tr>
<tr>
<td>Provider ID #: 2 (If Required)</td>
<td></td>
</tr>
<tr>
<td>Address: (Street #, City, State, Zip)</td>
<td></td>
</tr>
<tr>
<td>Phone Number: ( )</td>
<td>Facsimile/Data #: ( )</td>
</tr>
</tbody>
</table>

**Specialist Dentist**

<table>
<thead>
<tr>
<th>Name (Last, First, MI)</th>
<th>Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Office Name:</td>
<td>Dental Office Code:</td>
</tr>
<tr>
<td>Provider ID/License #:</td>
<td></td>
</tr>
<tr>
<td>Address: (Street #, City, State, Zip)</td>
<td></td>
</tr>
<tr>
<td>Phone Number: ( )</td>
<td>Facsimile/Data #: ( )</td>
</tr>
</tbody>
</table>

**Referral Information**

<table>
<thead>
<tr>
<th>Reason for Referral:</th>
<th>Brief History, Diagnosis, and Test Results:</th>
</tr>
</thead>
</table>

**Services Desired**: Provide Care as Indicated:

- [ ] Initial Consultation Only
- [ ] Consultation with Specific Procedures (Specify)
- [ ] Other: (Explain)

**Place of Service**:  
- [ ] Office
- [ ] Hospital
- [ ] Other: (Explain)

<table>
<thead>
<tr>
<th>Authorization # (If Required):</th>
<th>Referral is Valid Until: (Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(See Carrier Instructions)</td>
<td></td>
</tr>
</tbody>
</table>

**Signature**: (Individual Completing This Form)  
**Authorizing Signature**: (If Required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member’s eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Reverse and Carrier/Plan Manual for Specific Instructions
There are no special instructions in completing this form.
Check One
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

Please submit claim to: Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9416

1. Patient name
2. Relationship to employee
   self   spouse   child   other
3. Sex: m   f
4. Patient birth date: mo   day   year
5. If full time student school: city

6. Employee/subscriber name
   First   middle   last
7. Contact to:

8. Employee/subscriber mailing address
City, State, Zip

9. Group number
10. Location (Local)
11. Are other family members employed?
12. Contact ID #

13. Name and address of employer in item 13

14. Is patient covered by another dental plan?
   Yes   No

15. Dental plan name
   Union local   Group no.

16. Name and address of carrier

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signature (patient or patient minor) [ ]
Signature (insured person) [ ]

The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, United Concordia may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices.

For your protection California law requires that the following appear on the form: Any person who knowingly presents a false claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading another dental plan?

I hereby authorize payment directly to the below name dentist of the group insurance benefits otherwise payable to me.

Signature [ ]

16. Dentist name
24. Is treatment result of occupational illness or injury?
   No   Yes
   If yes, enter brief description and dates
25. Is treatment result of auto accident?
26. Other accident?
27. Are any services covered by another plan?

17. Mailing address
City, state, zip

18. Dentist soc. sec. or T.I.N.

19. Dentist license no.

20. Dentist phone no.

21. First visit date

22. Office
   Home   ECF   Other

23. Radiographs or models enclosed?
   No   Yes
24. Is treatment for orthodontics?
25. Is treatment result of auto accident?
26. Other accident?
27. Are any services covered by another plan?

28. If prosthesis, is placement?
29. Date of prior placement
30. Is treatment for orthodontics?
31. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown.

32. - Use charting system shown.

TOOTH NO. OR LETTER SURFACE DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) DATE SERVICE PERFORMED NO. LINE NO. PROCEDURE CODE FEE

33. Administration use only

For your protection California law requires that the following appear on the form: Any person who knowingly presents a false claim for the purpose of misleading another dental plan?

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signature (Dentist)

Date

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
<table>
<thead>
<tr>
<th>Mailing Addresses and Telephone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mailing Address for Claim Submission</strong></td>
</tr>
<tr>
<td>United Concordia Companies, Inc.</td>
</tr>
<tr>
<td>Attn: Claims Processing</td>
</tr>
<tr>
<td>PO Box 69422</td>
</tr>
<tr>
<td>Harrisburg, PA 17106-9422</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Mailing Address for Dental Electronic Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>United Concordia Companies, Inc.</td>
</tr>
<tr>
<td>Dental Electronic Services</td>
</tr>
<tr>
<td>PO Box 69408</td>
</tr>
<tr>
<td>Harrisburg, PA 17106-9408</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Mailing Address for Professional Relations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>United Concordia Companies, Inc.</td>
</tr>
<tr>
<td>Attn: Professional Relations</td>
</tr>
<tr>
<td>PO Box 69409</td>
</tr>
<tr>
<td>Harrisburg, PA 17106-9409</td>
</tr>
</tbody>
</table>

| **Telephone Numbers**                          |
| Customer Service                              |
| (866) 357-3304                                |

| Professional Relations                        |
| (800) 307-8514                                |

| Professional Relations                        |
| Request Open/Closed Status Fax:               |
| (866) 223-2770                                |

| **Website:**                                  |
| www.unitedconcordia.com                     |