101 Parklane Blvd, Ste 301, Sugar Land, TX 77478
www.fcldental.com / Credentialing@fcldental.com

PROVIDER APPLICATION

Provider Name:_____ **Provider NPI:** _____

FCL Provider Representative: _____

Please complete ALL blanks. If not applicable, please put "N/A". Any changes must be lined-through, initialed and dated. DO NOT USE WHITEOUT. Incomplete applications will delay processing time.

Your application materials will be reviewed and, if you are accepted as a participating Dentist, you will receive a credentialing approval letter welcoming you into our network.

If you have questions about plans in your state or need additional information, please call the Dentist Provider Line at: (877) 493-6262, 8 am – 5 pm cst, Monday – Friday or email us at: **Credentialing@fcldental.com**.

Once you have completed this Provider Application to join our network, please return the application, along with LEGIBLE copies of the following documents, to:

Email: Credentialing@fcldental.com OR
FAX: (832) 520-2564

☐	Completed Application with Work History (CV or Resume acceptable)
☐	Signed Dental Provider Agreement
☐	Copy of School Diploma
☐	Copy of Board Certifications & Hospital Privileges Letters (if applicable)
☐	Copy of Dental License (for all states in which you are licensed)
☐	Copy of Professional Liability Insurance Declaration page (with Expiration Date)
☐	Copy of CPR Certificate
☐	W-9 Form
☐	Copy of Radiation Certificate or Inspection Letter **(Texas Providers Only)**
☐	Copy of State Controlled Substance Certificate (if applicable in your state)
☐	Copy of DEA Controlled Substance Certificate

If you do not have a narcotics license, please include a signed statement indicating the name of the credentialed provider that will be available to write any necessary prescriptions.

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www.fcldental.com / Credentialing@fcldental.com

NETWORK ELECTION(S): Please choose the Plan(s) that you are interested in participating.

Nationwide Plans

- ☐ FCL PDP (PPO Plan)
- ☐ Medicare Plans for Any State Licensed to Do Business In
- ☐ Medicaid Plans – CAP Plan for Any State Licensed to Do Business In

Florida Plans

- ☐ FCL PDP (PPO Plan)
- ☐ Solis Health Plan (Medicare Advantage)
  **Providers in the following counties: Broward, Miami-Dade, Hillsborough, Palm Beach, Pinellas & Polk*

Louisiana Plans

- ☐ FCL PDP (PPO)
- ☐ DINA PPO
- ☐ DINA Pre-Paid
- ☐ Ochsner Health Plan (Medicare Advantage)
  **Providers located in following parishes (Excludes Pedodontists & Orthodontists): Ascension, East Baton Rouge, East Feliciana, Iberville, Jefferson, Lafourche, Livington, Orleans, St. Charles, St. John, St. Tammany & West Baton Rouge*

Kansas and Missouri Plans

- ☐ FCL PDP (PPO Plan)
- ☐ Dental Source – Plan E (DHMO)
- ☐ Dental Source – Plan H (DHMO)
- ☐ Free Access Plan (FAP)
- ☐ Safeguard

Tennessee and Mississippi Plans

- ☐ FCL PDP (PPO Plan)
- ☐ Dental Solutions Plus (Discount Plan

Texas Plans

- ☐ FCL PDP (PPO Plan)
- ☐ Community Health Choice – Expansion Plan (Medicaid & Requires Medicaid Provider Number)
  **Providers located in following counties: Austin, Chambers, Jasper, Hardin, Jefferson, Liberty, Matagorda, Newton, Orange, Polk, San Jacinto, Tyler, Walker & Wharton (Excludes Pedodontists & Orthodontists)*
- ☐ Community Health Choice – CAP Plan (Medicaid & Requires Medicaid Provider Number)
  **Providers located in following counties: Brazoria, Fort Bend, Galveston, Harris, Montgomery & Waller (Excludes Pedodontists & Orthodontists)*
- ☐ Community Health Choice – Expansion Plan (Medicaid & Requires Medicaid Provider Number)
  **Providers located in following counties: Austin, Chambers, Jasper, Hardin, Jefferson, Liberty, Matagorda, Newton, Orange, Polk, San Jacinto, Tyler, Walker & Wharton (Excludes Pedodontists & Orthodontists)*
- ☐ Community Health Choice – DSNP (Medicaid Provider Number)
  **Providers located in following counties: Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller & Wharton (Excludes Pedodontists & Orthodontists)*
- ☐ Kelsey Care Advantage (Medicare Advantage)
  **Providers located in following counties: Austin, Brazoria, Chambers, Fort Bend, Galveston, Grimes, Harris, Liberty, Montgomery, San Jacinto, Walker, Waller & Wharton (Excludes Pedodontists & Orthodontists)*
- ☐ OraQuest Dental Plan (DHMO)
  **Providers located in following counties: Angelina, Atascosa, Austin, Bandera, Bastrop, Bell, Bexar, Blanco, Bosque, Brazoria, Brazos, Burleson, Burnet, Caldwell, Calhoun, Chambers, Collin, Colorado, Comal, Comanche, Cooke, Coryell, Dallas, Denton, DeWitt, El Paso, Ellis, Erath, Falls, Fannin, Fayette, Fort Bend, Freestone, Frio, Galveston, Gillespie, Gonzales, Grayson, Grimes, Guadalupe, Hamilton, Hardin, Harris, Hays, Hill, Hood, Houston, Hurst, Jack, Jackson, Jasper, Jefferson, Johnson, Karnes, Kaufman, Kendall, Kerr, Lampasas, Lavaca, Lee, Leon, Liberty, Limestone, Llano, Madison, Matagorda, McLennan, Medina, Milam, Mills, Montague, Montgomery, Navarro, Newton, Nueces, Orange, Palo Pinto, Parker, Polk, Raines, Real, Robertson, Rockwall, San Jacinto, San Saba, Somervell, Tarrant, Travis, Trinity, Tyler, Uvalde, Van Zandt, Walker, Waller, Washington, Wharton, Williamson, Wilson & Wise*
- ☐ Texas Children's Health Plan – CAP Plan (Medicaid & Requires Medicaid Provider Number)
  **Providers located in following counties: Brazoria, Fort Bend, Galveston, Harris, Montgomery & Waller (Excludes Pedodontists & Orthodontists)*
- ☐ Texas Children's Health Plan – Expansion Plan (Medicaid & Requires Medicaid Provider Number)
  **Providers located in following counties: Austin, Chambers, Jasper, Hardin, Jefferson, Liberty, Matagorda, Newton, Orange, Polk, San Jacinto, Tyler, Walker & Wharton (Excludes Pedodontists & Orthodontists)*

Third Party Opt Outs

- ☐ Zelis – Provider does NOT wish to participate

Provider Application

Reset Form

CORRECT NUMBERS AND LETTERS A B C 1 2 3 CORRECT MARK X INCORRECT MARKS

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 Personal Information and Professional IDs

Provider Type

Code list is found on page 36. Enter the associated 3-digit code in the space provided.*

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.) YES NO

Name

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

Click for Code Lists

LAST NAME* SUFFIX (JR, III)

FIRST NAME* MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME SUFFIX (JR, III)

OTHER FIRST NAME OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (MMDDYYYY) DATE STOPPED USING OTHER NAME (MMDDYYYY)

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.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER* MALE FEMALE DATE OF BIRTH* (MMDDYYYY)

CITY OF BIRTH STATE OF BIRTH COUNTRY OF BIRTH

SSN* FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK

LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE

Home Address

NUMBER STREET APT NUMBER

CITY STATE ZIP CODE

TELEPHONE

NOTE: CAQH will use this method for application follow-up.

E-MAIL

FAX

PREFERRED METHOD OF CONTACT* E-MAIL FAX

3076

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

Std. App. v.5.0
Reprinted on 10/31/06

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

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.

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

Click for Code Lists

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Other ID Numbers

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

ARE YOU A PARTICIPATING MEDICARE PROVIDER?* YES NO

MEDICARE NUMBER

UPIN

ARE YOU A PARTICIPATING MEDICAID PROVIDER?* YES NO

MEDICAID NUMBER

MEDICAID STATE

NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER

USMLE NUMBER (WITHOUT HYPHENS)

WORKERS COMPENSATION NUMBER

0 — — —

ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)

ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) (M M D D Y Y Y Y)

3077

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

Section 2 — Education and Training

Undergraduate School(s)

Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.

Professional School(s)

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

Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and the Fifth Pathway institution where you completed your training on Supplemental Page 20.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.

Click for Code Lists

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY | STATE | ZIP/POSTAL CODE

COUNTRY CODE | TELEPHONE | FAX

START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

GRADUATE TYPE*:

☐ U.S. OR CANADIAN GRADUATE ☐ NON-U.S./CANADIAN GRADUATE ☐ FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./ CANADIAN ONLY) | NAME OF U.S./ CANADIAN SCHOOL:

START DATE* (MMYYYY) | END DATE (GRADUATION DATE)* (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY | COUNTRY CODE | POSTAL CODE

START DATE* (MMYYYY) | END DATE (GRADUATION DATE)* (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

* 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.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 21.

Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by the organization for which you are being credentialed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

Click for Code Lists

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE - -

FAX - -

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? YES NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y
START DATE

M M Y Y Y Y
END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y
START DATE

M M Y Y Y Y
END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y
START DATE

M M Y Y Y Y
END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

3080

* 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 3 — Professional / Medical Specialty Information

Primary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

Click for Code Lists

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

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.

Secondary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Professional / Medical Specialties to report, use the Additional Specialties Supplemental Form on page 22.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

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.

3081

* 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 3 — Professional / Medical Specialty Information (Continued)

Certifications

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

			EXPIRATION DATE				EXPIRATION DATE
BASIC LIFE SUPPORT?*	☐ YES	☐ NO	M M D D Y Y Y Y	ADV LIFE SUPPORT IN OB?*	☐ YES	☐ NO	M M D D Y Y Y Y
CPR?*	☐ YES	☐ NO	M M D D Y Y Y Y	ADV TRAUMA LIFE SUPPORT?*	☐ YES	☐ NO	M M D D Y Y Y Y
ADV CARDIAC LIFE SPT?*	☐ YES	☐ NO	M M D D Y Y Y Y	PEDIATRIC ADVANCED LIFE SPT?*	☐ YES	☐ NO	M M D D Y Y Y Y
NEONATAL ADVANCED LIFE SPT?*	☐ YES	☐ NO	M M D D Y Y Y Y				

Practice Interests

Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.

Primary Credentialing Contact

CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE CREDENTIALING INFORMATION. ☐

LAST NAME

FIRST NAME | M.I.

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

E-MAIL ADDRESS

NOTE:

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

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

Section 4 — Practice Location Information

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

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

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

PREVIOUS OR FUTURE START DATE? M M D D Y Y Y Y

PHYSICIAN 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

INDIVIDUAL TAX ID | GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* ☐ USE INDIVIDUAL TAX ID ☐ USE GROUP TAX ID

Office Manager or Business Office Staff 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.

LAST NAME*

FIRST NAME* | M.I.

TELEPHONE* | FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

LAST NAME*

FIRST NAME* | M.I.

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

TELEPHONE* | FAX

E-MAIL ADDRESS

3083

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

Section 4 — Practice Location Information (Continued)

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* ☐ YES ☐ NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION ☐

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Payee Contact.

Office Hours

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

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?* ☐ YES ☐ NO

IF YES ☐ ANSWERING SERVICE ☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE ☐ VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

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 MEDICARE PATIENTS?* ☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* ☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?* ☐ YES ☐ NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)

ARE THERE ANY PRACTICE LIMITATIONS?* ☐ YES ☐ NO

IF YES

GENDER LIMITATIONS ☐ MALE ONLY ☐ FEMALE ONLY ☐ NONE

AGE LIMITATIONS MINIMUM AGE MAXIMUM AGE

LIST OTHER LIMITATIONS

3084

* 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 4 — Practice Location Information (Continued)

Mid-Level Practitioners

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* ☐ YES ☐ NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

3085

* 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 37. Enter the associated 3-digit code in the space provided.

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* ☐ YES ☐ NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

Click for Code Lists

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

OTHER HANDICAPPED ACCESS

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

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* ☐ YES ☐ NO

- BUS* ☐ YES ☐ NO
- SUBWAY* ☐ YES ☐ NO
- REGIONAL TRAIN* ☐ YES ☐ NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? ☐ YES ☐ NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES? ☐ YES ☐ NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? ☐ YES ☐ NO	ALLERGY INJECTIONS? ☐ YES ☐ NO	ALLERGY SKIN TESTING? ☐ YES ☐ NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? ☐ YES ☐ NO
DRAWING BLOOD? ☐ YES ☐ NO	AGE APPROPRIATE IMMUNIZATIONS? ☐ YES ☐ NO	FLEXIBLE SIGMOIDOSCOPY? ☐ YES ☐ NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? ☐ YES ☐ NO
ASTHMA TREATMENT? ☐ YES ☐ NO	OSTEOPATHIC MANIPULATION? ☐ YES ☐ NO	IV HYDRATION/ TREATMENT? ☐ YES ☐ NO	CARDIAC STRESS TEST? ☐ YES ☐ NO
PULMONARY FUNCTION TESTING? ☐ YES ☐ NO	PHYSICAL THERAPY? ☐ YES ☐ NO	CARE OF MINOR LACERATIONS? ☐ YES ☐ NO	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? ☐ YES ☐ NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? LAST NAME | FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* ☐ SOLO PRACTICE ☐ SINGLE SPECIALTY GROUP ☐ MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

3086

* 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 4 — Practice Location Information (Continued)

Partners/ Associates

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

Click for Code Lists

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

Section 5 — Hospital Affiliations

Admitting Arrangements

DO YOU HAVE HOSPITAL PRIVILEGES?* ☐ YES ☐ NO

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

3087

* 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 5 — Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

PRIMARY HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (MMYYYY) | AFFILIATION END DATE (MMYYYY) | FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (MMYYYY) | AFFILIATION END DATE (MMYYYY) | FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION

3088

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

Section 6 — Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT
IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION. ☐

CARRIER OR SELF-INSURED NAME* | SELF-INSURED?* ☐ YES ☐ NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* ☐ YES ☐ NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional Insurance, use the Supplemental Insurance Form on page 31.

CARRIER OR SELF-INSURED NAME | SELF-INSURED? ☐ YES ☐ NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? ☐ YES ☐ NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Section 7 — Work History and References

Military Duty

Are you currently on active military duty or military reserve?* ☐ YES ☐ NO

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

If you have additional work history, use the Supplemental Work History Form on page 32.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

3089

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 healthcare entity

If you have additional work history, use the Supplemental Work History Form on page 32.

Click for Code Lists

TELEPHONE | FAX

COUNTRY CODE | START DATE (M M Y Y Y Y) | END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (M M Y Y Y Y) | END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (M M Y Y Y Y) | END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

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

Section 7 — Work History and References (Continued)

Gaps in Professional / Work History

If you have additional professional / work history gaps, use the Supplemental Professional Work History Gaps Form on page 33.

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.

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

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 36-43. 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.

Click for Code Lists

Reference 1

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Reference 2

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Reference 3

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

3091

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

Section 8 — Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

Allied Health Providers

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

LICENSURE

1. ☐ YES ☐ NO 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?*
2. ☐ YES ☐ NO Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ☐ YES ☐ NO 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?*
4. ☐ YES ☐ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
5. ☐ YES ☐ NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ☐ YES ☐ NO 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?*
7. ☐ YES ☐ NO 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?*
8. ☐ YES ☐ NO Have any of your board certifications or eligibility ever been revoked?*
9. ☐ YES ☐ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. ☐ YES ☐ NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. ☐ YES ☐ NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*

OTHER SANCTIONS OR INVESTIGATIONS

12. ☐ YES ☐ NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or 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?*
13. ☐ YES ☐ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
14. ☐ YES ☐ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
15. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, pled nolo contendere 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?*
16. ☐ YES ☐ NO 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?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ☐ YES ☐ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
18. ☐ YES ☐ NO 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?*

3092

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

Section 8 — Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

IMPORTANT
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

19. ☐ YES ☐ NO 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.

CRIMINAL/CIVIL HISTORY

20. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*

21. ☐ YES ☐ NO 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?*

22. ☐ YES ☐ NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

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.

ABILITY TO PERFORM JOB

23. ☐ YES ☐ NO Are you currently engaged in the illegal use of drugs?*
("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. ☐ YES ☐ NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*

25. ☐ YES ☐ NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

26. ☐ YES ☐ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, 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 "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect 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, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

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

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

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

3094

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

Professional IDs Supplemental Form

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

Section 1 — Personal Information and Professional IDs

Professional IDs

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

Provide all current and previous licenses/ certifications.

If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.

Click for Code Lists

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Other Relevant Education
Supplemental Form

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

Section 2 — Education and Training

Fifth Pathway Education

FIFTH PATHWAY GRADUATES ONLY

INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE)

ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

START DATE (M M Y Y Y Y) | END DATE (GRADUATION DATE) (M M Y Y Y Y)

Other Relevant Education

If you need to report additional Education, photocopy this page as needed and submit as instructed.

Click for Code Lists

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (M M Y Y Y Y) | END DATE (GRADUATION DATE) (M M Y Y Y Y) | DEGREE AWARDED

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (M M Y Y Y Y) | END DATE (GRADUATION DATE) (M M Y Y Y Y) | DEGREE AWARDED

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

Other Training
Supplemental Form

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

Section 2 Education and Training

Training

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

If you need to report additional Training, photocopy this page as needed and submit as instructed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

Click for Code Lists

INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? ☐ YES ☐ NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

☐ INTERNSHIP/ RESIDENCY ☐ FELLOWSHIP ☐ OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

☐ INTERNSHIP/ RESIDENCY ☐ FELLOWSHIP ☐ OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

☐ INTERNSHIP/ RESIDENCY ☐ FELLOWSHIP ☐ OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

3096

Additional Specialty Supplemental Form

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

Section 3 — Professional / Medical Specialty Information

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

Click for Code Lists

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM

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.

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Specialties, photocopy this page as needed and submit as instructed.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

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.

3097

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

Partners/Associates
Supplemental Form

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

Section 4 — Practice Location Information

Partner/ Associates

Use this page to report additional partners/associates at the designated practice location.

IMPORTANT

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

Check "Covering Colleague?" if he/she provides coverage for you at THIS location.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional partners/associates, photocopy this page as needed and submit as instructed.

Click for Code Lists

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # ____ ☐ PRIMARY PRACTICE

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

3098

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

Covering Colleagues
Supplemental Form

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

Section 4 — **Practice Location Information**

Covering Colleagues

Include all colleagues providing regular coverage and his/her specialty, including if he/she is a partner in one or more of your practice locations.

IMPORTANT

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

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Covering Colleagues, photocopy this page as needed and submit as instructed.

Click for Code Lists

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # ____ ☐ PRIMARY PRACTICE

PRACTICE NAME ____

PRACTICE ADDRESS ____

LAST NAME ____ SPECIALTY CODE ____
FIRST NAME ____ M.I. ____ PROVIDER TYPE (CODE PG 36) ____

LAST NAME ____ SPECIALTY CODE ____
FIRST NAME ____ M.I. ____ PROVIDER TYPE (CODE PG 36) ____

LAST NAME ____ SPECIALTY CODE ____
FIRST NAME ____ M.I. ____ PROVIDER TYPE (CODE PG 36) ____

LAST NAME ____ SPECIALTY CODE ____
FIRST NAME ____ M.I. ____ PROVIDER TYPE (CODE PG 36) ____

LAST NAME ____ SPECIALTY CODE ____
FIRST NAME ____ M.I. ____ PROVIDER TYPE (CODE PG 36) ____

LAST NAME ____ SPECIALTY CODE ____
FIRST NAME ____ M.I. ____ PROVIDER TYPE (CODE PG 36) ____

LAST NAME ____ SPECIALTY CODE ____
FIRST NAME ____ M.I. ____ PROVIDER TYPE (CODE PG 36) ____

LAST NAME ____ SPECIALTY CODE ____
FIRST NAME ____ M.I. ____ PROVIDER TYPE (CODE PG 36) ____

3099

Practice Location Information
Supplemental Form

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

Section 4 | **Practice Location Information - Page 1 of 5**

Additional Practice Location

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.

LOCATION* # ☐☐

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

PREVIOUS OR FUTURE START DATE? M M D D Y Y Y Y

PHYSICIAN 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 CORRESPON-DENCE HERE?* ☐ YES ☐ NO

TELEPHONE* | FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID | GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* ☐ USE INDIVIDUAL TAX ID ☐ USE GROUP TAX ID

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.

LAST NAME*

FIRST NAME* | M.I.

TELEPHONE* | FAX

E-MAIL ADDRESS

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.

LAST NAME*

FIRST NAME* | M.I.

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

TELEPHONE* | FAX

E-MAIL ADDRESS

3100

Practice Location Information
Supplemental Form

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

Section 4 | **Practice Location Information - Page 2 of 5**

Add'l Practice Location (Cont.)

LOCATION* # ☐

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* ☐ YES ☐ NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

Office Hours

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

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?* ☐ YES ☐ NO

IF YES ☐ ANSWERING SERVICE ☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE ☐ VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

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 MEDICARE PATIENTS?* ☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* ☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?* ☐ YES ☐ NO

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* ☐ YES ☐ NO

IF YES

GENDER LIMITATIONS ☐ MALE ONLY ☐ NONE ☐ FEMALE ONLY

AGE LIMITATIONS ☐ MINIMUM AGE ☐ MAXIMUM AGE

LIST OTHER LIMITATIONS

3101

* 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 4 | **Practice Location Information - Page 3 of 5**

Additional Practice Location
(Continued)

IMPORTANT

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

LOCATION* # ☐

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* ☐ YES ☐ NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

Mid-Level Practitioners

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

3102

* 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 4 | **Practice Location Information - Page 4 of 5**

Additional Practice Location (Continued)

IMPORTANT

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

LOCATION* #

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

Click for Code Lists

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

OTHER HANDICAPPED ACCESS

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

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES? YES NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? YES NO	ALLERGY INJECTIONS? YES NO	ALLERGY SKIN TESTING? YES NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO
DRAWING BLOOD? YES NO	AGE APPROPRIATE IMMUNIZATIONS? YES NO	FLEXIBLE SIGMOIDOSCOPY? YES NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? YES NO
ASTHMA TREATMENT? YES NO	OSTEOPATHIC MANIPULATION? YES NO	IV HYDRATION/ TREATMENT? YES NO	CARDIAC STRESS TEST? YES NO
PULMONARY FUNCTION TESTING? YES NO	PHYSICAL THERAPY? YES NO	CARE OF MINOR LACERATIONS? YES NO	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? — LAST NAME — FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

3103

* 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 4 | **Practice Location Information - Page 5 of 5**

Additional Practice Location
(Continued)

IMPORTANT

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

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

Click for Code Lists

LOCATION* # ☐☐

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

3104

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

Hospital Privileges (Current)
Supplemental Form

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

Section 5 | **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (MMYYYY) | AFFILIATION END DATE (MMYYYY)

FULL, UNRESTRICTED PRIVILEGES? YES NO

ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

Professional Liability Insurance Carrier
Supplemental Form

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

Section 6 | **Professional Liability Insurance Carrier**

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

CARRIER OR SELF-INSURED NAME | SELF-INSURED? ☐ YES ☐ NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? ☐ YES ☐ NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

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.

CARRIER OR SELF-INSURED NAME | SELF-INSURED? ☐ YES ☐ NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? ☐ YES ☐ NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Work History
Supplemental Form

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

Section 7 — Work History

Work History

Use this form to continue listing work history.

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

Click for Code Lists

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (MMYYYY)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (MMYYYY)

REASON FOR DEPARTURE (IF APPLICABLE)

Professional Training / Work History Gaps
Supplemental Form

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

Section 7 | **Professional Training / Work History Gaps**

Professional Training / Work History Gaps

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 month in duration or of a shorter duration if required by the organization for which you are being credentialed.

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

3108

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

Disclosure Questions
Supplemental Form

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

Section 8 | **Disclosure Questions**

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.

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

3109

Malpractice Claims Explanation
Supplemental Form

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

Section 8 — Malpractice Claims Explanation

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.

DATE OF OCCURRENCE* (M M D D Y Y Y Y)

DATE CLAIM WAS FILED* (M M D D Y Y Y Y)

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

☐ OPEN ☐ CLOSED

IF SETTLED, ENTER DATE CLAIM WAS SETTLED (M M D D Y Y Y Y)

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

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

TELEPHONE (- -) | POLICY NUMBER

$. AMOUNT OF AWARD OR SETTLEMENT*

METHOD OF RESOLUTION?* ☐ DISMISSED ☐ SETTLED ☐ MEDIATION ☐ ARBITRATION ☐ JUDGMENT FOR DEFENDANT(S) ☐ JUDGMENT FOR PLAINTIFF(S)

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

WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?* ☐ PRIMARY DEFENDANT ☐ CO-DEFENDANT

NUMBER OF OTHER CO-DEFENDANTS (IF ANY)

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? ☐ YES ☐ NO

TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?* ☐ YES ☐ NO

3110

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

Return to Previous View

Code Lists

Provider Type Codes

001 Medical Doctor (MD)
002 Doctor of Dental Surgery (DDS)
003 Doctor of Dental Medicine (DMD)
004 Doctor of Podiatric Medicine (DPM)
005 Doctor of Chiropractic (DC)
007 Osteopathic Doctor (DO)

020 Acupuncturist
021 Alcohol/Drug Counselor
022 Audiologist
023 Biofeedback Technician
024 Certified Registered Nurse Anesthetist
025 Christian Science Practitioner
026 Clinical Nurse Specialist
027 Clinical Psychologist
028 Clinical Social Worker
029 Dietician
030 Licensed Practical Nurse
031 Marriage/Family Therapist
032 Massage Therapist
033 Naturopath
034 Neuropsychologist
035 Midwife
036 Nurse Midwife
037 Nurse Practitioner
038 Nutritionist
039 Occupational Therapist
040 Optician
041 Optometrist
042 Pharmacist
043 Physical Therapist
044 Physician Assistant
045 Professional Counselor
046 Registered Nurse
047 Registered Nurse First Assistant
048 Respiratory Therapist
049 Speech Pathologist

License Status Codes

001 Active
002 Canceled
003 Denied
004 Expired
005 Inactive
006 Lapsed
007 Limited
008 Pending
009 Probation
010 Provisional
011 Restricted
012 Revoked
013 Suspended
014 Surrendered
015 Temporary
016 Terminated
017 Time Limited
018 Unrestricted
019 Other

Country Codes

004 Afghanistan
008 Albania
012 Algeria
016 American Samoa
020 Andorra
024 Angola
660 Anguilla
010 Antarctica
028 Antigua and Barbuda
032 Argentina
051 Armenia
533 Aruba
036 Australia
040 Austria
031 Azerbaijan
044 Bahamas
048 Bahrain
050 Bangladesh
052 Barbados
112 Belarus
056 Belgium
084 Belize
204 Benin
060 Bermuda
064 Bhutan
068 Bolivia
070 Bosnia and Herzegovina
072 Botswana
074 Bouvet Island
076 Brazil
086 British Indian Ocean Territory
096 Brunei Darussalam
100 Bulgaria
854 Burkina Faso
108 Burundi
116 Cambodia
120 Cameroon
124 Canada
132 Cape Verde
136 Cayman Islands
140 Central African Republic
148 Chad
152 Chile
156 China
162 Christmas Island
166 Cocos (Keeling) Islands
170 Colombia
174 Comoros
178 Congo
180 Congo, Democratic Republic of the
184 Cook Islands
188 Costa Rica
384 Cote d'Ivoire
191 Croatia
192 Cuba
196 Cyprus
203 Czech Republic
208 Denmark
262 Djibouti
212 Dominica
214 Dominican Republic
626 East Timor (provisional)
218 Ecuador
818 Egypt
222 El Salvador
226 Equatorial Guinea
232 Eritrea
233 Estonia
231 Ethiopia
238 Falkland Islands (Malvinas)
234 Faroe Islands
242 Fiji
246 Finland
250 France
249 France, Metropolitan
254 French Guiana
258 French Polynesia
260 French Southern Territories
266 Gabon
270 Gambia
268 Georgia
276 Germany
288 Ghana
292 Gibraltar
300 Greece
304 Greenland
308 Grenada
312 Guadaloupe
316 Guam
320 Guatemala
324 Guinea
624 Guinea-Bissau
328 Guyana
332 Haiti
334 Heard Island and McDonald Islands
340 Honduras
344 Hong Kong
348 Hungary
352 Iceland
356 India
360 Indonesia
364 Iran
368 Iraq
372 Ireland
376 Israel
380 Italy
388 Jamaica
392 Japan
400 Jordan
398 Kazakhstan
404 Kenya
296 Kiribati
408 Korea, North
410 Korea, South
414 Kuwait
417 Kyrgyzstan
418 Laos
428 Latvia
422 Lebanon
426 Lesotho
430 Liberia
434 Libya
438 Liechtenstein
440 Lithuania
442 Luxembourg
446 Macau
807 Macedonia
450 Madagascar
454 Malawi
458 Malaysia
462 Maldives
466 Mali
470 Malta
584 Marshall Islands
474 Martinique
478 Mauritania
480 Mauritius
175 Mayotte
484 Mexico
583 Micronesia
498 Moldova
492 Monaco
496 Mongolia
500 Montserrat
504 Morocco
508 Mozambique
104 Myanmar
516 Namibia
520 Nauru
524 Nepal
528 Netherlands
530 Netherlands Antilles
540 New Caledonia
554 New Zealand
558 Nicaragua
562 Niger
566 Nigeria
570 Niue
574 Norfolk Island
580 Northern Mariana Islands
578 Norway
512 Oman
586 Pakistan
585 Palau
591 Panama
598 Papua New Guinea
600 Paraguay
604 Peru
608 Philippines
612 Pitcairn
616 Poland
620 Portugal
630 Puerto Rico
634 Qatar
638 Réunion
642 Romania
643 Russian Federation
646 Rwanda
654 Saint Helena
659 Saint Kitts and Nevis
662 Saint Lucia
666 Saint Pierre and Miquelon
670 Saint Vincent and the Grenadines

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Code Lists

Country Codes (continued)

882 Samoa
674 San Marino
678 São Tomé and Príncipe
682 Saudi Arabia
683 Scotland
686 Senegal
690 Seychelles
694 Sierra Leone
702 Singapore
703 Slovakia
705 Slovenia
090 Solomon Islands
706 Somalia
710 South Africa
239 South Georgia and the South Sandwich Islands
724 Spain
144 Sri Lanka
736 Sudan
740 Suriname
744 Svalbard and Jan Mayen
748 Swaziland
752 Sweden
756 Switzerland
760 Syria
158 Taiwan
762 Tajikistan
834 Tanzania
764 Thailand
768 Togo
772 Tokelau
776 Tonga
780 Trinidad and Tobago
788 Tunisia
792 Turkey795 Turkmenistan
796 Turks and Caicos Islands
798 Tuvalu
800 Uganda
804 Ukraine
784 United Arab Emirates
826 United Kingdom
840 United States
581 U.S. Minor Outlying Islands
858 Uruguay
860 Uzbekistan
548 Vanuatu
336 Vatican City State (Holy See)
862 Venezuela
704 Viet Nam
092 Virgin Islands, British
850 Virgin Islands, U.S.
876 Wallis and Fortuna Islands
732 Western Sahara (provisional)
887 Yemen
891 Yugoslavia
894 Zambia
716 Zimbabwe

Language Codes

001 Abkhazian
002 Afan (Oromo)
003 Afar
004 Afrikaans
005 Albanian
006 Amharic
007 Arabic
008 Armenian
009 Assamese
010 Zerbaijani
011 Bashkir
012 Basque
013 Bengali;Bangla
014 Bhutani
015 Bihari
016 Bislama
017 Breton
018 Bulgarian
019 Burmese
020 Byelorussian
021 Cambodian
022 Catalan
023 Chinese
024 Corsican
025 Croatian
026 Czech
027 Danish
028 Dutch
140 English
030 Esperonto
031 Estonian
032 Faroese
033 Fiji
034 Finnish
035 French
036 Frisian
037 Galican
038 Georgian
039 German
040 Greek
041 Greenlandic
042 Guarani
043 Gujarati
044 Hausa
045 Hebrew
046 Hindi
047 Hungarian
048 Icelandic
049 Indonesian
050 Interlingua
051 Interlingue
052 Inuktitut
053 Inupiak
054 Irish
055 Italian
056 Japanese
057 Javanese
058 Kannada
059 Kashmiri
060 Kazakh
061 Kinyarwanda
062 Kirghiz
063 Kurundi
064 Korean
065 Kurdish
066 Laothian
067 Latin
068 Latvian;Lettish
069 Lingala
070 Lithuanian
071 Macedonian
072 Malagasy
073 Malay
074 Malayalam
075 Maltese
076 Maori
077 Marathi
078 Moldavian
079 Mongolian
080 Nauru
081 Nepali
082 Norwegian
083 Occitan
084 Oriya
085 Pashto;Pushto
086 Persian (Farsi)
087 Polish
088 Portuguese
089 Punjabi
090 Quechua
091 Rhaeto-Romance
092 Romanian
093 Russian
094 Samoan
095 Sangho
096 Sanskrit
097 Scot Gaelic
098 Serbian
099 Serbo-Croatian
100 Sesotho
101 Setswana
102 Shona
103 Sindhi
104 Singhalese
105 Siswati
106 Slovak
107 Slovenian
108 Somali
109 Spanish
110 Sundanese
111 Swahili
112 Swedish
113 Tagalog
114 Tajik
115 Tamil
116 Tatar
117 Telugu
118 Thai
119 Tibetan
120 Tigrinya
121 Tonga
122 Tsonga
123 Turkish
124 Turkmen
125 Twi
126 Uigur
127 Ukrainian
128 Urdu
129 Uzbek
130 Vietnamese
131 Volapuk
132 Welsh
133 Wolof
134 Xhosa
135 Yiddish
136 Yoruba
10 Zerbaijani
137 Zhuang
138 Zulu

Code Lists

U.S. / Canadian Professional School Codes

Alabama
300 University of Alabama School of Dentistry
001 University of Alabama School of Medicine
002 University of South Alabama College of Medicine

Arkansas
003 University of Arkansas College of Medicine

Arizona
500 Arizona College of Osteopathic Medicine
004 University of Arizona College of Medicine

California
801 California College of Podiatric Medicine
400 Cleveland Chiropractic College of Los Angele
005 Keck School of Medicine
401 Life Chiropractic College West
301 Loma Linda University School of Dentistry
006 Loma Linda University School of Medicine
402 Los Angeles College of Chiropractic
403 Palmer College of Chiropractic West
404 Quantum University/SCCC
007 Stanford University School of Medicine
501 Touro University College of Osteopathic Medicine
008 UCLA School of Medicine
009 University of California
010 University of California, Irvine, College of Medicine
302 University of California, Los Angeles School of Dentistry
011 University of California, San Diego, School of Medicine
303 University of California, San Francisco, School of Dentistry
012 University of California, San Francisco, School of Medicine
304 University of Southern California School of Dentistry
305 University of the Pacific School of Dentistry
502 Western University of Health Sciences, College of Osteopathic Medicine of the Pacific

Colorado
306 University of Colorado School of Dentistry
013 University of Colorado School of Medicine

Connecticut
405 University of Bridgeport College of Chiropractic
307 University of Connecticut School of Dental Medicine
014 University of Connecticut School of Medicine
015 Yale University School of Medicine

District of Columbia
016 George Washington University
017 Georgetown University School of Medicine
308 Howard University College of Dentistry
018 Howard University College of Medicine

Florida
800 Barry University School of Graduate Medical Sciences
309 Nova Southeastern University College of Dentistry
503 Nova Southeastern University College of Osteopathic Medicine
310 University of Florida College of Dentistry
019 University of Florida College of Medicine
020 University of Miami School of Medicine
021 University of South Florida College of Medicine

Georgia
022 Emory University School of Medicine
406 Life Chiropractic College
311 Medical College of Georgia School of Dentistry
023 Medical College of Georgia School of Medicine
024 Mercer University School of Medicine
025 Morehouse School of Medicine

Hawaii
026 John A. Burns School of Medicine

Iowa
802 College of Podiatric Medicine and Surgery Des Moines University
504 Des Moines University, Osteopathic Medical Center, College of Osteopathic Medicine and Surgery
407 Palmer College of Chiropractic
312 University of Iowa College of Dentistry
027 University of Iowa College of Medicine

Illinois
028 Chicago Medical School, Finch University of Health Sciences
029 Loyola University Chicago, Stritch School of Medicine
505 Midwestern University, Chicago College of Osteopathic Medicine
408 National College of Chiropractic
313 Northwestern University Dental School
030 Northwestern University Medical School
031 Rush Medical College of Rush University
804 Scholl College of Podiatric Medicine at Finch University
314 Southern Illinois University School of Dental Medicine
032 Southern Illinois University School of Medicine
033 University of Chicago, The Pritzker School of Medicine
315 University of Illinois at Chicago College of Dentistry
034 University of Illinois College of Medicine

Indiana
316 Indiana University School of Dentistry
035 Indiana University School of Medicine

Kansas
036 University of Kansas School of Medicine

Kentucky
506 Pikeville College, School of Osteopathic Medicine
317 University of Kentucky College of Dentistry
037 University of Kentucky College of Medicine
318 University of Louisville School of Dentistry
038 University of Louisville School of Medicine

Louisiana
319 Louisiana State University School of Dentistry
039 Louisiana State University School of Medicine in New Orleans
040 Louisiana State University School of Medicine in Shreveport
041 Tulane University School of Medicine

Massachusetts
042 Boston University School of Medicine
320 Boston University, Goldman School of Dental Medicine
043 Harvard Medical School
321 Harvard School of Dental Medicine
322 Tufts University School of Dental Medicine
044 Tufts University School of Medicine
045 University of Massachusetts Medical School

Maryland
046 Johns Hopkins University School of Medicine
047 Uniformed Services University of the Health Sciences
048 University of Maryland School of Medicine
323 University of Maryland, Baltimore, College of Dental Surgery

Maine
507 University of New England, College of Osteopathic Medicine

Michigan
049 Michigan State University College of Human Medicine
508 Michigan State University, College of Osteopathic Medicine
324 University of Detroit Mercy School of Dentistry
050 University of Michigan Medical School
325 University of Michigan School of Dentistry
051 Wayne State University School of Medicine

Minnesota
052 Mayo Medical School
409 Northwestern College of Chiropractic
053 University of Minnesota, Duluth School of Medicine
054 University of Minnesota Medical School, Twin Cities
326 University of Minnesota School of Dentistry

Missouri
410 Cleveland Chiropractic College of Kansas City
509 Kirksville College of Osteopathic Medicine
411 Logan Chiropractic College
055 Saint Louis University School of Medicine
510 University of Health Sciences, College of Osteopathic Medicine

056 University of Missouri, Columbia School of Medicine
327 University of Missouri Kansas City School of Dentistry
057 University of Missouri Kansas City School of Medicine
058 Washington University in St. Louis School of Medicine

Code Lists

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

Mississippi
328 University of Mississippi School of Dentistry
059 University of Mississippi School of Medicine

North Carolina
060 Duke University School of Medicine
061 The Brody School of Medicine at East Carolina University
329 University of North Carolina at Chapel Hill School of Dentistry
062 University of North Carolina at Chapel Hill School of Medicine
063 Wake Forest University School of Medicine

North Dakota
064 University of North Dakota School of Medicine and Health Sciences

Nebraska
330 Creighton University School of Dentistry
065 Creighton University School of Medicine
066 University of Nebraska College of Medicine
331 University of Nebraska Medical Center, College of Dentistry

New Hampshire
067 Dartmouth Medical School

New Jersey
068 Robert Wood Johnson Medical School
069 University of Medicine and Dentistry of New Jersey (UMDNJ)
332 UMDNJ, New Jersey Dental School
511 UMDNJ, School of Osteopathic Medicine

New Mexico
070 University of New Mexico School of Medicine

Nevada
071 University of Nevada School of Medicine

New York
072 Albany Medical College
073 Albert Einstein College of Medicine
074 Columbia University College of Physicians and Surgeons
333 Columbia University School of Dental and Oral Surgery
075 Joan & Sanford I. Weill Medical College of Cornell University
076 Mount Sinai School of Medicine of New York University
412 New York Chiropractic College
512 NY College of Osteopathic Medicine of the NY Institute of Technology
077 New York Medical College
334 New York University Kriser Dental Center
078 New York University School of Medicine
335 State University of New York at Buffalo School of Dental Medicine
082 State University of New York at Buffalo School of Medicine
336 State University of New York at Stony Brook School of Dental Medicine
081 State University of New York at Stony Brook School of Medicine
079 State University of New York College of Medicine
080 State University of New York Upstate Medical University
083 University of Rochester School of Medicine and Dentistry

Ohio
337 Case Western Reserve University School of Dentistry
084 Case Western Reserve University School of Medicine
085 Medical College of Ohio
086 Northeastern Ohio Universities College of Medicine
803 Ohio College of Podiatric Medicine
338 Ohio State University College of Dentistry
087 Ohio State University College of Medicine and Public Health
513 Ohio University College of Osteopathic Medicine
088 University of Cincinnati College of Medicine
089 Wright State University School of Medicine

Oklahoma
514 Oklahoma State University, College of Osteopathic Medicine
339 University of Oklahoma College of Dentistry
090 University of Oklahoma College of Medicine

Oregon
091 Oregon Health & Science University School of Medicine
340 Oregon Health Sciences University School of Dentistry
413 Western States Chiropractic College

Pennsylvania
092 Jefferson Medical College of Thomas Jefferson University
515 Lake Erie College of Osteopathic Medicine
093 MCP Hahnemann University School of Medicine
094 Pennsylvania State University College of Medicine
516 Philadelphia College of Osteopathic Medicine
341 Temple University School of Dentistry
095 Temple University School of Medicine
805 Temple University School of Podiatric Medicine
342 University of Pennsylvania School of Dental Medicine
096 University of Pennsylvania School of Medicine
343 University of Pittsburgh School of Dental Medicine
097 University of Pittsburgh School of Medicine

Puerto Rico
098 Ponce School of Medicine
099 Universidad Central del Caribe School of Medicine
100 University of Puerto Rico School of Medicine
344 University of Puerto Rico School of Dentistry

Rhode Island
101 Brown Medical School

South Carolina
345 Medical University of South Carolina College of Dental Medicine
102 Medical University of South Carolina College of Medicine
414 Sherman College of Chiropractic
103 University of South Carolina School of Medicine

South Dakota
104 University of South Dakota School of Medicine

Tennessee
105 East Tennessee State University
346 Meharry Medical College School of Dentistry
106 Meharry Medical College School of Medicine
347 University of Tennessee College of Dentistry
107 University of Tennessee College of Medicine
108 Vanderbilt University School of Medicine

Texas
348 Baylor College of Dentistry
109 Baylor College of Medicine
415 Parker College of Chiropractic
416 Texas Chiropractic College
110 Texas Tech University Health Sciences Center School of Medicine
111 The Texas A & M University System College of Medicine
517 UNT Health Sciences Center, Texas College of Osteopathic Medicine
349 University of Texas Health Science Center at Houston Dental School
350 University of Texas Health Science Center at San Antonio Dental School
112 University of Texas Medical Branch at Galveston
113 University of Texas Medical School at Houston
114 University of Texas Medical School at San Antonio
115 UT Southwestern Medical Center at Dallas Southwestern Medical School

Utah
116 University of Utah School of Medicine

Virginia
117 Eastern VA Medical School of the Medical College of Hampton Roads
118 University of Virginia School of Medicine Health System
351 Virginia Commonwealth University School of Dentistry
119 Virginia Commonwealth University School of Medicine

Vermont
120 University of Vermont College of Medicine

Washington
352 University of Washington School of Dentistry
121 University of Washington School of Medicine

Wisconsin
353 Marquette University School of Dentistry
122 Medical College of Wisconsin
123 University of Wisconsin Medical School

West Virginia
124 Joan C. Edwards School of Medicine at Marshall University
518 West Virginia School of Osteopathic Medicine
354 West Virginia University School of Dentistry
125 West Virginia University School of Medicine

Code Lists

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

Canada

355 Dalhousie University Faculty of Dentistry
126 Dalhousie University Faculty of Medicine
357 Laval University Faculty of Dentistry
127 Laval University Faculty of Medicine
356 McGill University Faculty of Dentistry
128 McGill University Faculty of Medicine
129 McMaster University School of Medicine
130 Memorial University of Newfoundland Faculty of Medicine
131 Queen's University Faculty of Health Sciences
132 The University of Western Ontario Faculty of Medicine & Dentistry
133 Universite de Montreal Faculty of Medicine
134 Universite de Sherbrooke Faculty of Medicine
358 University of Alberta Faculty of Dentistry
135 University of Alberta Faculty of Medicine
359 University of British Columbia Faculty of Dentistry
136 University of British Columbia Faculty of Medicine
137 University of Calgary Faculty of Medicine
360 University of Manitoba Faculty of Dentistry
138 University of Manitoba Faculty of Medicine
361 University of Montreal Faculty of Dentistry
139 University of Ottawa Faculty of Medicine
362 University of Saskatchewan College of Dentistry
140 University of Saskatchewan College of Medicine
363 University of Toronto Faculty of Dentistry
141 University of Toronto Faculty of Medicine
364 University of Western Ontario Faculty of Dentistry

Specialty Codes - MD / DO Only

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

247 Allergy & Immunology
246 Allergy & Immunology, Allergy
291 Allergy & Immunology, Clinical & Laboratory Immunology
249 Anesthesiology
235 Anesthesiology, Addiction Medicine
258 Anesthesiology, Critical Care Medicine
126 Anesthesiology, Pain Medicine
363 Clinical Pharmacology
367 Colon & Rectal Surgery
263 Dermatology
292 Dermatology, Clinical & Laboratory Dermatological Immunology
444 Dermatology, Dermatological Surgery
266 Dermatology, Dermatopathology
264 Dermatology, MOHS-Micrographic Surgery
443 Dermatology, Pediatric Dermatology
268 Emergency Medicine
445 Emergency Medicine, Emergency Medical Services
427 Emergency Medicine, Medical Toxicology
348 Emergency Medicine, Pediatric Emergency Medicine
395 Emergency Medicine, Sports Medicine
446 Emergency Medicine, Undersea and Hyperbaric Medicine
391 Facial Plastic Surgery
272 Family Practice
447 Family Practice, Addiction Medicine
237 Family Practice, Adolescent Medicine
448 Family Practice, Adult Medicine
282 Family Practice, Geriatric Medicine
396 Family Practice, Sports Medicine
225 General Practice
479 Hospitalist
301 Internal Medicine
449 Internal Medicine, Addiction Medicine
236 Internal Medicine, Adolescent Medicine
248 Internal Medicine, Allergy & Immunology
255 Internal Medicine, Cardiovascular Disease
294 Internal Medicine, Clinical & Laboratory Immunology
253 Internal Medicine, Clinical Cardiac Electrophysiology
257 Internal Medicine, Critical Care Medicine
267 Internal Medicine, Endocrinology, Diabetes & Metabolism
275 Internal Medicine, Gastroenterology
285 Internal Medicine, Geriatric Medicine
287 Internal Medicine, Hematology
288 Internal Medicine, Hematology & Oncology
450 Internal Medicine, Hepatology
299 Internal Medicine, Infectious Disease
451 Internal Medicine, Interventional Cardiology
453 Internal Medicine, Magnetic Resonance Imaging (MRI)
325 Internal Medicine, Medical Oncology
309 Internal Medicine, Nephrology
378 Internal Medicine, Pulmonary Disease
390 Internal Medicine, Rheumatology
802 Internal Medicine, Sleep Medicine
397 Internal Medicine, Sports Medicine
433 Laboratories, Clinical Medical Laboratory
481 Legal Medicine
278 Medical Genetics, Clinical Biochemical Genetics
261 Medical Genetics, Clinical Cytogenetic
277 Medical Genetics, Clinical Genetics (M.D.)
280 Medical Genetics, Clinical Molecular Genetics
455 Medical Genetics, Molecular Genetic Pathology
454 Medical Genetics, Ph.D. Medical Genetics
306 Neonatal-Perinatal Medicine
308 Neopathology
409 Neurological Surgery
330 Neuromusculoskeletal Medicine & OMM
440 Neuromusculoskeletal Medicine, Sports Medicine
317 Nuclear Medicine
318 Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine
315 Nuclear Medicine, Nuclear Cardiology
316 Nuclear Medicine, Nuclear Imaging & Therapy
321 Obstetrics & Gynecology
260 Obstetrics & Gynecology, Critical Care Medicine
326 Obstetrics & Gynecology, Gynecologic Oncology
286 Obstetrics & Gynecology, Gynecology
303 Obstetrics & Gynecology, Maternal & Fetal Medicine
320 Obstetrics & Gynecology, Obstetrics
271 Obstetrics & Gynecology, Reproductive Endocrinology
328 Ophthalmology
441 Oral & Maxillofacial Surgery
411 Orthopaedic Surgery
412 Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery
456 Orthopaedic Surgery, Foot and Ankle Orthopaedics
406 Orthopaedic Surgery, Hand Surgery
415 Orthopaedic Surgery, Orthopaedic Surgery of the Spine
416 Orthopaedic Surgery, Orthopaedic Trauma
803 Orthopaedic Surgery, Pediatric Orthopaedic Surgery
457 Orthopaedic Surgery, Sports Medicine
119 Orthopedic
331 Otolaryngology
458 Otolaryngology, Otolaryngic Allergy
459 Otolaryngology, Otolaryngology/ Facial Plastic Surgery
332 Otolaryngology, Otology & Neurotology
357 Otolaryngology, Pediatric Otolaryngology
417 Otolaryngology, Plastic Surgery within the Head & Neck
804 Otolaryngology, Sleep Medicine
480 Pain Medicine, Interventional Pain Medicine
337 Pain Medicine
338 Pathology, Anatomic Pathology
340 Pathology, Anatomic Pathology & Clinical Pathology
250 Pathology, Blood Banking & Transfusion Medicine
344 Pathology, Chemical Pathology
302 Pathology, Clinical Pathology/Laboratory Medicine
262 Pathology, Cytopathology
265 Pathology, Dermatopathology
273 Pathology, Forensic Pathology
290 Pathology, Hematology
298 Pathology, Immunopathology
305 Pathology, Medical Microbiology
461 Pathology, Molecular Genetic Pathology
312 Pathology, Neuropathology
358 Pathology, Pediatric Pathology
244 Pediatrics
805 Pediatric Anesthesiology
239 Pediatrics, Adolescent Medicine
295 Pediatrics, Clinical & Laboratory Immunology
462 Pediatrics, Developmental – Behavioral Pediatrics
354 Pediatrics, Medical Toxicology
356 Pediatrics, Neurodevelopmental Disabilities
345 Pediatrics, Pediatric Allergy & Immunology

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Code Lists

Specialty Codes - MD/DO Only

346	Pediatrics, Pediatric Cardiology
347	Pediatrics, Pediatric Critical Care Medicine
463	Pediatrics, Pediatric Emergency Medicine
349	Pediatrics, Pediatric Endocrinology
350	Pediatrics, Pediatric Gastroenterology
351	Pediatrics, Pediatric Hematology-Oncology
352	Pediatrics, Pediatric Infectious Diseases
355	Pediatrics, Pediatric Nephrology
359	Pediatrics, Pediatric Pulmonology
361	Pediatrics, Pediatric Rheumatology
806	Pediatrics, Sleep Medicine
398	Pediatrics, Sports Medicine
365	Physical Medicine & Rehabilitation
468	Physical Medicine & Rehabilitation, Pain Medicine
389	Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine
466	Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine
469	Physical Medicine & Rehabilitation, Sports Medicine
419	Plastic Surgery
470	Plastic Surgery, Plastic Surgery Within the Head and Neck
407	Plastic Surgery, Surgery of the Hand
242	Preventive Medicine, Aerospace Medicine
429	Preventive Medicine, Medical Toxicology
112	Preventive Medicine, Occupational Medicine
471	Preventive Medicine, Sports Medicine
431	Preventive Medicine, Undersea and Hyperbaric Medicine
114	Preventive Medicine/Occupational Environmental Medicine
370	Psychiatry & Neurology, Addiction Medicine
473	Psychiatry & Neurology, Addiction Psychiatry
371	Psychiatry & Neurology, Child & Adolescent Psychiatry
313	Psychiatry & Neurology, Clinical Neurophysiology
274	Psychiatry & Neurology, Forensic Psychiatry
373	Psychiatry & Neurology, Geriatric Psychiatry
472	Psychiatry & Neurology, Neurodevelopmental Disabilities
100	Psychiatry & Neurology, Neurology
311	Psychiatry & Neurology, Neurology with Special Qualifications in Child Neurology
474	Psychiatry & Neurology, Pain Medicine
368	Psychiatry & Neurology, Psychiatry
809	Psychiatry & Neurology, Sleep Medicine
475	Psychiatry & Neurology, Sports Medicine
476	Psychiatry & Neurology, Vascular Neurology
366	Public Health & General Preventive Medicine
252	Radiology, Body Imaging
173	Radiology, Diagnostic Radiology
430	Radiology, Diagnostic Ultrasound
314	Radiology, Neuroradiology
319	Radiology, Nuclear Radiology
360	Radiology, Pediatric Radiology
380	Radiology, Radiation Oncology
477	Radiology, Radiological Physics
381	Radiology, Therapeutic Radiology
384	Radiology, Vascular & Interventional Radiology
434	Supplier
399	Surgery
418	Surgery, Pediatric Surgery
420	Surgery, Plastic and Reconstructive Surgery
405	Surgery, Surgery of the Hand
425	Surgery, Surgical Critical Care
413	Surgery, Surgical Oncology
423	Surgery, Trauma Surgery
400	Surgery, Vascular Surgery
421	Thoracic Surgery (Cardiothoracic Vascular Surgery)
442	Transplant Surgery
424	Urology
811	Urology, Pediatric Urology

Specialty Codes - DDS / DMD / DPM / DC

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

DDS / DMD

2	Dentist
13	Dentist, Dental Public Health
14	Dentist, Endodontics
438	Dentist, General Practice
16	Dentist, Oral and Maxillofacial Pathology
439	Dentist, Oral and Maxillofacial Radiology
20	Dentist, Oral and Maxillofacial Surgery
15	Dentist, Orthodontics and Dentofacial Orthopedics
17	Dentist, Pediatric Dentistry
18	Dentist, Periodontics
19	Dentist, Prosthodontics

DPM

3	Podiatrist
231	Podiatrist, Foot & Ankle Surgery
230	Podiatrist, Foot Surgery
227	Podiatrist, Primary Podiatric Medicine
226	Podiatrist, Public Medicine
228	Podiatrist, Radiology
229	Podiatrist, Sports Medicine

DC

1	Chiropractor
5	Chiropractor, Internist
6	Chiropractor, Neurology
7	Chiropractor, Nutrition
8	Chiropractor, Occupational Medicine
9	Chiropractor, Orthopedic
10	Chiropractor, Radiology
801	Chiropractor, Rehabilitation Specialization
11	Chiropractor, Sports Physician
12	Chiropractor, Thermography

Specialty Codes - Allied Providers

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

501	Acupuncturist
503	Audiologist
504	Audiologist, Assistive Technology Practitioner
505	Audiologist, Assistive Technology Supplier
531	Christian Science Practitioner
727	Clinical Nurse Specialist
728	Clinical Nurse Specialist, Acute Care
729	Clinical Nurse Specialist, Adult Health
730	Clinical Nurse Specialist, Chronic Care
731	Clinical Nurse Specialist, Community Health/Public Health
732	Clinical Nurse Specialist, Critical Care Medicine
733	Clinical Nurse Specialist, Emergency
734	Clinical Nurse Specialist, Ethics
735	Clinical Nurse Specialist, Family Health
736	Clinical Nurse Specialist, Gerontology
737	Clinical Nurse Specialist, Holistic
738	Clinical Nurse Specialist, Home Health
739	Clinical Nurse Specialist, Informatics
740	Clinical Nurse Specialist, Long-Term Care
741	Clinical Nurse Specialist, Medical-Surgical
742	Clinical Nurse Specialist, Neonatal
743	Clinical Nurse Specialist, Neuroscience
744	Clinical Nurse Specialist, Occupational Health
745	Clinical Nurse Specialist, Oncology
746	Clinical Nurse Specialist, Oncology, Pediatrics
747	Clinical Nurse Specialist, Pediatrics
748	Clinical Nurse Specialist, Perinatal
749	Clinical Nurse Specialist, Perioperative
750	Clinical Nurse Specialist, Psychiatric/Mental Health
751	Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
752	Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent
753	Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
754	Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
755	Clinical Nurse Specialist, Psychiatric/Mental Health, Community
756	Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
757	Clinical Nurse Specialist, Rehabilitation
759	Clinical Nurse Specialist, School
758	Clinical Nurse Specialist, Transplantation
760	Clinical Nurse Specialist, Women's Health
513	Counselor
514	Counselor, Addiction (Substance Use Disorder)
515	Counselor, Mental Health
516	Counselor, Professional
533	Dietitian, Registered
536	Dietitian, Registered, Nutrition, Metabolic
534	Dietitian, Registered, Nutrition, Pediatric
535	Dietitian, Registered, Nutrition, Renal
651	Licensed Practical Nurse
517	Marriage & Family Therapist
547	Massage Therapist
549	Midwife, Certified
652	Midwife, Certified Nurse
551	Naturopath
553	Neuropsychologist
653	Nurse Anesthetist, Certified Registered
654	Nurse Practitioner
655	Nurse Practitioner, Acute Care
656	Nurse Practitioner, Adult Health
658	Nurse Practitioner, Community Health
657	Nurse Practitioner, Critical Care Medicine
659	Nurse Practitioner, Family

Code Lists

Specialty Codes - Allied Providers (continued)

660 Nurse Practitioner, Gerontology
661 Nurse Practitioner, Neonatal
662 Nurse Practitioner, Neonatal, Critical Care
670 Nurse Practitioner, Obstetrics & Gynecology
671 Nurse Practitioner, Occupational Health
663 Nurse Practitioner, Pediatrics
664 Nurse Practitioner, Pediatrics, Critical Care
666 Nurse Practitioner, Perinatal
667 Nurse Practitioner, Primary Care
665 Nurse Practitioner, Psych/Mental Health
668 Nurse Practitioner, School
669 Nurse Practitioner, Women's Health
537 Nutritionist
538 Nutritionist, Nutrition, Education
555 Occupational Therapist
556 Occupational Therapist, Ergonomics
557 Occupational Therapist, Hand
558 Occupational Therapist, Human Factors
559 Occupational Therapist, Neurorehabilitation
560 Occupational Therapist, Pediatrics
561 Occupational Therapist, Rehabilitation, Driver
563 Optician
565 Optometrist
566 Optometrist, Corneal and Contact Management
567 Optometrist, Low Vision Rehabilitation
571 Optometrist, Occupational Vision
568 Optometrist, Pediatrics
569 Optometrist, Sports Vision
570 Optometrist, Vision Therapy
573 Pharmacist
574 Pharmacist, General Practice
807 Pharmacist, Geriatric
575 Pharmacist, Nuclear
576 Pharmacist, Nutrition Support
808 Pharmacist, Oncology
577 Pharmacist, Pharmacotherapy
578 Pharmacist, Psychiatric
580 Physical Therapist
581 Physical Therapist, Cardiopulmonary
583 Physical Therapist, Electrophysiology, Clinical
582 Physical Therapist, Ergonomics
584 Physical Therapist, Geriatrics
585 Physical Therapist, Hand
586 Physical Therapist, Human Factors
587 Physical Therapist, Neurology
590 Physical Therapist, Orthopedic
588 Physical Therapist, Pediatrics
589 Physical Therapist, Sports
592 Physician Assistant
593 Physician Assistant, Medical
594 Physician Assistant, Surgical
596 Psychologist
597 Psychologist, Addiction (Substance Use Disorder)
598 Psychologist, Adult Development & Aging
599 Psychologist, Behavioral
602 Psychologist, Child, Youth & Family
600 Psychologist, Clinical
601 Psychologist, Counseling
603 Psychologist, Educational
604 Psychologist, Exercise & Sports
605 Psychologist, Family
606 Psychologist, Forensic
607 Psychologist, HealthService
608 Psychologist, Men & Masculinity
609 Psychologist, Mental Retardation & Developmental Disabilities
610 Psychologist, Psychoanalysis
611 Psychologist, Psychotherapy
612 Psychologist, Psychotherapy, Group
613 Psychologist, Rehabilitation
614 Psychologist, School
615 Psychologist, Women
672 Registered Nurse
673 Registered Nurse, Addiction (Substance Use Disorder)
674 Registered Nurse, Administrator
711 Registered Nurse, Ambulatory Care
681 Registered Nurse, Cardiac Rehabilitation
676 Registered Nurse, Case Management
677 Registered Nurse, College Health
678 Registered Nurse, Community Health
680 Registered Nurse, Continence Care
679 Registered Nurse, Continuing Education/Staff Development
675 Registered Nurse, Critical Care Medicine
682 Registered Nurse, Diabetes Educator
683 Registered Nurse, Dialysis, Peritoneal
684 Registered Nurse, Emergency
685 Registered Nurse, Enterostomal Therapy
686 Registered Nurse, Flight
688 Registered Nurse, Gastroenterology
687 Registered Nurse, General Practice
689 Registered Nurse, Gerontology
691 Registered Nurse, Hemodialysis
690 Registered Nurse, Home Health
692 Registered Nurse, Hospice
694 Registered Nurse, Infection Control
693 Registered Nurse, Infusion Therapy
695 Registered Nurse, Lactation Consultant
696 Registered Nurse, Maternal Newborn
697 Registered Nurse, Medical-Surgical
699 Registered Nurse, Neonatal Intensive Care
700 Registered Nurse, Neonatal, Low-Risk
701 Registered Nurse, Nephrology
702 Registered Nurse, Neuroscience
698 Registered Nurse, Nurse Massage Therapist (NMT)
703 Registered Nurse, Nutrition Support
719 Registered Nurse, Obstetric, High-Risk
720 Registered Nurse, Obstetric, Inpatient
721 Registered Nurse, Occupational Health
722 Registered Nurse, Oncology
725 Registered Nurse, Ophthalmic
724 Registered Nurse, Orthopedic
726 Registered Nurse, Ostomy Care
723 Registered Nurse, Otorhinolaryngology & Head-Neck
704 Registered Nurse, Pain Management
706 Registered Nurse, Pediatric Oncology
705 Registered Nurse, Pediatrics
710 Registered Nurse, Perinatal
714 Registered Nurse, Plastic Surgery
708 Registered Nurse, Psych/Mental Health
709 Registered Nurse, Psych/Mental Health, Adult
707 Registered Nurse, Psych/Mental Health, Child & Adolescent
810 Registered Nurse, Registered Nurse First Assistant
712 Registered Nurse, Rehabilitation
713 Registered Nurse, Reproductive Endocrinology/Infertility
715 Registered Nurse, School
716 Registered Nurse, Urology
718 Registered Nurse, Women's Health Care, Ambulatory
717 Registered Nurse, Wound Care
617 Respiratory Therapist, Certified
618 Respiratory Therapist, Certified, Critical Care
620 Respiratory Therapist, Certified, Educational
619 Respiratory Therapist, Certified, Emergency Care
622 Respiratory Therapist, Certified, General Care
621 Respiratory Therapist, Certified, Geriatric Care
623 Respiratory Therapist, Certified, Home Health
628 Respiratory Therapist, Certified, Neonatal/Pediatrics
627 Respiratory Therapist, Certified, Palliative/Hospice
629 Respiratory Therapist, Certified, Patient Transport
624 Respiratory Therapist, Certified, Pulmonary Diagnostics
626 Respiratory Therapist, Certified, Pulmonary Function Technologist
625 Respiratory Therapist, Certified, Pulmonary Rehabilitation
630 Respiratory Therapist, Certified, SNF/Subacute Care
631 Respiratory Therapist, Registered
632 Respiratory Therapist, Registered, Critical Care
634 Respiratory Therapist, Registered, Educational
633 Respiratory Therapist, Registered, Emergency Care
636 Respiratory Therapist, Registered, General Care
635 Respiratory Therapist, Registered, Geriatric Care
637 Respiratory Therapist, Registered, Home Health
642 Respiratory Therapist, Registered, Neonatal/Pediatrics
641 Respiratory Therapist, Registered, Palliative/Hospice
643 Respiratory Therapist, Registered, Patient Transport
638 Respiratory Therapist, Registered, Pulmonary Diagnostics
640 Respiratory Therapist, Registered, Pulmonary Function Technologist
639 Respiratory Therapist, Registered, Pulmonary Rehabilitation
644 Respiratory Therapist, Registered, SNF/Subacute Care
646 Social Worker, Clinical
648 Specialist/Technologist, Other, Biomedical Engineering
506 Speech-Language Pathologist
649 Technician, Other, Biomedical Engineering
502 Other, Not Listed

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Code Lists

Specialty Boards - Allied Providers

940 Academy of Certified Social Workers
1150 ACNM Certification Council
360 American Academy of Ambulatory Care Nursing
1550 American Academy of Anesthesiologist Assistants
230 American Academy of Audiology
370 American Academy of Experts in Traumatic Stress
270 American Academy of Health Providers in the Addictive Disorders
200 American Academy of Medical Acupuncture
405 American Academy of Nurse Practitioners
380 American Academy of Nursing
1330 American Academy of Optometry
1480 American Academy of Physician Assistants
1110 American Association for Marriage and Family Therapy
390 American Association of Critical Care Nurses
1590 American Association of Nurse Anesthetists
330 American Association of Pastoral Counselors
1010 American Association of Sex Educators, Counselors and Therapists
710 American Board Medical Psychotherapists
280 American Board of Addiction Medicine
950 American Board of Examiners in Clinical Social Work
720 American Board of Medical Psyhotherapists & Psychodiagnosticians
400 American Board of Nursing Specialties
1240 American Board of Nutrition
1300 American Board of Occupational Medicine
1360 American Board of Ophthalmology
1510 American Board of Physical Therapy Specialties
700 American Board of Professional Psychology
1130 American Naturopath Certification Board
350 American Nurses Credentialing Center
740 American Psychological Association
750 American Psychological Society
760 American Psychotherapy Association
290 American Society of Addiction Medicine
1650 American Speech-Language-Hearing Association
250 Biofeedback Certification Institute of America
1430 Board of Pharmaceutical Specialties
1250 Commission on Dietetic Registration
960 Employee Assistance Professionals Association
780 National Association for the Advancement of Psychoanalysis
1450 National Association of Boards of Pharmacy
1600 National Association of Nurse Anesthetists
770 National Association of School Psychologists
980 National Association of Social Workers
1310 National Board for Certification in Occupational Therapy
1490 National Board for Certification of Orthopaedic Physician Assistants
790 National Board for Certified Clinical Hypnotherapists
310 National Board for Certified Counselors
1630 National Board for Respiratory Care
300 National Board of Addiction Examiners
800 National Board of Cognitive Behavioral Therapists
1350 National Board of Examiners in Optometry
1090 National Certification Board for Therapeutic Massage and Bodywork
210 National Certification Commission for Acupuncture and Oriental Medicine
1440 National Institute for Standards in Pharmacist Credentialing
220 Other - Not Listed

Specialty Boards - MD / DDS / DMD / DO / DPM

MD Boards

044 American Board of Allergy & Immunology
045 American Board of Anesthesiology
046 American Board of Colon & Rectal Surgery
047 American Board of Dermatology
048 American Board of Emergency Medicine
049 American Board of Family Medicine
050 American Board of Internal Medicine
051 American Board of Medical Genetics
052 American Board of Neurological Surgery
053 American Board of Nuclear Medicine
054 American Board of Obstetrics & Gynecology
055 American Board of Ophthalmology
109 American Board of Oral & Maxillofacial Surgeons
056 American Board of Orthopaedic Surgery
057 American Board of Otolaryngology
058 American Board of Pathology
059 American Board of Pediatrics
060 American Board of Physical Medicine & Rehabilitation
061 American Board of Plastic Surgery
062 American Board of Preventive Medicine
063 American Board of Psychiatry & Neurology
064 American Board of Radiology
065 American Board of Surgery
066 American Board of Thoracic Surgery
067 American Board of Urology
142 Boards other than ABMS/AOA

Dental Boards

113 American Board of Endodontics
114 American Board of Oral & Maxillofacial Pathology
117 American Board of Oral & Maxillofacial Radiology
109 American Board of Oral & Maxillofacial Surgeons
108 American Board of Orthodontics
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

DO Boards

118 American Osteopathic Board of Anesthesiology
119 American Osteopathic Board of Dermatology
120 American Osteopathic Board of Emergency Medicine
121 American Osteopathic Board of Family Practice
123 American Osteopathic Board of Internal Medicine
124 American Osteopathic Board of Neurology and Psychiatry
125 American Osteopathic Board of Neuromuskuloskeletal Medicine
126 American Osteopathic Board of Nuclear Medicine
127 American Osteopathic Board of Obstetrics and Gynecology
128 American Osteopathic Board of Ophthalmology and Otolaryngology
129 American Osteopathic Board of Orthopedic Surgery
130 American Osteopathic Board of Pathology
131 American Osteopathic Board of Pediatrics
132 American Osteopathic Board of Preventive Medicine
133 American Osteopathic Board of Proctology
134 American Osteopathic Board of Radiology
135 American Osteopathic Board of Rehabilitation Medicine
136 American Osteopathic Board of Surgery

DPM Boards

140 American Board of Medical Specialists in Podiatry
137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine
138 American Board of Podiatric Surgery
139 American Council of Certified Podiatric Surgeons and Physicians

DENTAL PROVIDER AGREEMENT

THIS AGREEMENT is made this _____ day of _____, 20_____ by and between the two parties ("Parties") First Continental Life and Accident Insurance Company (FCL DENTAL) a Texas life, health, and accident insurance Company, and _____ ("Dentist").

WITNESSETH:

WHEREAS FCL DENTAL has organized a life, health, and accident insurance company under the laws of the State of Texas and desires to make contractual arrangements for its Members (hereinafter defined) under which Dentist (hereinafter defined) agrees to furnish dental and related services to Members; and

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

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

This Agreement, together with the Provider Application Form constitutes the entire agreement of the parties.

ARTICLE I - DEFINITIONS

1.1 ACT shall mean the Texas Health Maintenance Organization Act (Texas Insurance Code Chapter 20A) and the applicable rules and regulations promulgated under or pursuant thereto.

1.2 FEE-FOR-SERVICE shall mean a method of payment for dental services rendered. Fee-for-service is the traditional payment system under which providers receive a payment for each procedure provided rather than a capitation payment for each recipient.

1.3 CLEAN CLAIM shall mean a claim which does not require outside development or any further investigation and can be processed immediately. A claim does not meet the definition of "clean" if any additional information must be requested from the beneficiary, Dentist, supplier or other outside services. This includes routine data omitted from the bill, dental information, or information to resolve discrepancies.

1.4 PROVIDER (DENTIST) : (1) any individual who is engaged in the delivery of dental / health care services in a State and is licensed or certified by the State Board of Dental Examiners to engage in that activity in the State in which the Provider practices, and has a contract in effect with FCL Dental to furnish dental services to eligible members /enrollees ; and (2) any entity that is engaged in the delivery of dental/ health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

1.5 DENTAL DIRECTOR shall mean the individual or group of individuals appointed by FCL DENTAL to maintain professional standards for the dentists contracting with FCL DENTAL.

1.6 DENTAL PLANS shall mean various plans outlining terms of coverage for Individuals and Groups as defined in the Fee Schedules attached hereto.

1.7 DENTAL SERVICE AGREEMENT shall mean the agreement between FCL DENTAL and an organization for dental services, or in the case of an individual, the agreement between a Member and FCL DENTAL. This agreement will include, but is not limited to, a schedule of benefits offered to the Member.

1.8 DENTIST USUAL AND CUSTOMARY RATES (Dentist UCR) shall mean the normal rates charged by Dentist's office for services.

1.9 FIRST CONTINENTAL LIFE AND ACCIDENT INSURANCE COMPANY (FCL Dental) shall mean a life, health, and accident insurance company domiciled in the state of Texas, operating pursuant to the Act which arranges for dental/ health care services to Members that are set forth herein. Should FCL DENTAL elect to contract the administration of its services to a third party, then references to FCL DENTAL can mean the third party administrator.

1.10 EMERGENCY DENTAL CARE or EMERGENCY DENTAL SERVICES shall mean emergency dental services provided in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

1.11 MEMBER or *ENROLLEE* shall mean an Enrolled Subscriber or Enrolled Dependent in an FCL DENTAL Plan.

1.12 DENTAL SERVICES shall mean the dental procedures, which FCL DENTAL includes in its marketed products.

1.13 SPECIALTY DENTAL SERVICES shall mean all dental procedures, in which the Dentist normally refers to a Specialist.

1.14 NECESSARY DENTAL SERVICE shall mean a dental procedure(s) which the Dental Director determines is necessary to establish or maintain the oral health of a Member.

1.15 CENTERS FOR MEDICARE AND MEDICAID SERVICES ("CMS") shall mean the agency within the Department of Health and Human Services that administers the Medicare program.

1.16 COMPLETION OF AUDIT shall mean completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

1.17 DOWNSTREAM ENTITY shall mean any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.18 FINAL CONTRACT PERIOD shall mean the final term of the contract between CMS and the Medicare Advantage Organization.

1.19 FIRST TIER ENTITY shall mean any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

1.20 MEDICARE ADVANTAGE ("MA") shall mean an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

1.21 MEDICARE ADVANTAGE ORGANIZATION ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

1.22 RELATED ENTITY: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

ARTICLE II - RELATIONSHIP OF PARTIES

2.1 Basic Relationship. FCL DENTAL and the Dentist are separate and independent entities. Dentist shall render his/her services under this Agreement as an independent contractor. As independent contracting parties, FCL DENTAL and the Dentist maintain separate and independent management, and each has full unrestricted authority and responsibility regarding its own organization and structure. Nothing contained herein shall be deemed or construed to make Dentist, or any of his/her employees or other persons acting under his/her direction or control, an agent, employee, servant, partner, or joint venture of or with FCL DENTAL.

ARTICLE III - DUTIES OF DENTAL PROVIDER

3.1 Dentist agrees to:

A. Provide those dental services set forth in the provided Fee Schedule and/or in the applicable plan Product Attachment for all Members selecting a Dentist, subject to any Exclusions and Limitations.

B. Render the services provided by this Agreement in a timely manner consistent with the professional and ethical standards of the American Dental Association ("ADA"). All such services shall be provided in the best possible manner in light of the technology and medical knowledge which is available at the time the services are rendered.

C. Refer Members for appropriate specialty care, where needed, and not provided by Dentist. Any such referrals for specialty care must be in compliance with FCL DENTAL's specialty care referral system as set forth in the FCL DENTAL Provider Manual. Provide twenty-four (24) hour emergency services and treat emergency patients within 24 hours at the office or the hospital Emergency Room. Dentist shall inform eligible Members how to contact Dentist for the delivery of such services in accordance with the Dentist's normal office policy.

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

E. Complaint Notice Dentist shall post in Dentist's office(s) a notice to Members regarding the process for resolving complaints with FCL DENTAL. This notice must include the State specific Department of Insurance toll-free telephone number for filing complaints.

D. The Network Dentist understands and agrees that OIG, CMS, and/or HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Member complaints.

3.2 Discrimination. Dentist shall not differentiate or discriminate in the treatment of his/her patients by reason of sex, race, nationality, religion, health or economic status.

3.3 Administrative. To enable FCL DENTAL to implement appropriate quality assurance and utilization review programs and to comply with Federal and State rules and regulations thereunder, Dentist shall:

A. Agree to provide to FCL DENTAL an accurate description of all services rendered to FCL DENTAL Members on ADA claim forms, electronic or written. The forms shall be completed and submitted to FCL DENTAL as services are performed, but in no case less frequently than 95 days after date of service.

B. Cooperate with FCL DENTAL in maintaining and providing such dental, administrative, and other records relating to a Member as may be requested by FCL DENTAL. When provided to FCL DENTAL, these records shall maintain the confidential nature they had while in the possession of Dentist.

C. Cooperate and participate with FCL DENTAL in service standards, quality assurance, peer review and audit systems, on-site inspections, and grievance procedures, as set forth by FCL DENTAL. Dentist shall comply with all final determinations rendered by the peer review process, or as set forth within the FCL DENTAL provider manual.

D. Cooperate with FCL DENTAL by providing updated copies of state licenses, DEA Controlled Substances Certificates, Controlled Substances Certificates (if applicable), Radiation Certifications, and Malpractice Insurance Policies as these certificates and policies renew.

E. Cooperate with FCL DENTAL in maintaining records and files relating to Dentist by informing FCL DENTAL in writing of any changes to the information provided to FCL DENTAL on the Dentist Application.

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

3.5 Inspection. Dentist agrees to allow inspection, during normal business hours, of books and records to the extent of its dealings with FCL DENTAL under this contract by FCL DENTAL, and authorized authorities of the State in which the provider practices.

3.6 Extended Leave. Whenever Dentist is on vacation or is to be absent for any extended period, Dentist shall refer all members to FCL DENTAL. Failure to meet the terms of this paragraph may result in adjustments to reimbursements. Not applicable to open access programs.

3.7 Subcontracting. Both parties agree that neither can assign nor subcontract their rights, duties or obligations under this Agreement, in whole or in part without prior written consent.

A. Leasing of Network. Network Provider acknowledges that (a) Network's arrangements with its Customers for access to the Contract Rate described in this Agreement may be deemed to be network "rental," "lease," or "sale" arrangements under some state or federal laws, and (b) some state or federal laws require specific disclosure of such arrangements. Accordingly, to the extent that the terms "rent," "lease," or "sale" apply to Network's Customer arrangements as contemplated under this Agreement, Network and Network Provider agree that Network and its affiliates may lease, sell, rent or otherwise grant access to Network Provider's Contract Rate to third parties, including other preferred provider organizations. Each Customer's entitlement to the Contract Rate under this Agreement is subject to such Customer's compliance with the applicable terms of this Agreement.

3.8 Acceptance of New Members. Dentist agrees to accept all Members referred by FCL DENTAL. In the event the Dentist chooses to no longer accept additional new patients, dentist may request FCL DENTAL to inactivate his/her practice. FCL DENTAL may accept such inactivation immediately or within a time period that Dentist and FCL DENTAL may mutually agree; however, in no event shall Dentist be required to wait more than 90 days to be inactivated. Prior to the effective date of any such inactivation approval by FCL DENTAL, Dentist shall accept any and all new Members referred to a Dentist and shall render treatment and services to all new Members subject to the terms of this contract. After inactivation, Dentist's name will then be removed from all future printings of FCL DENTAL materials and Dentist may only then refuse to accept new Members or those Members other than those who have already selected, or been assigned to him/her. Not applicable to open access programs.

3.9 Patient Relationship. Subject only to the quality assurance standards set forth in this agreement, the Dentist shall be solely responsible for all dental advice and services rendered to a Member.

3.10 Transfer of Patients. Because the dentist-patient relationship is personal and may become unacceptable to either party, Member or Dentist may request in writing to FCL DENTAL that the Member be transferred to another Dentist. Such transfers will be made by FCL DENTAL after consulting with its client.

3.11 Refusal of Services. Dentist shall have the right to refuse services to any Member who habitually has broken appointments or has behaved in a grossly discourteous manner toward Dentist, Dentist's employees and/or other patients. Dentist shall promptly report to FCL DENTAL all such instances where Dentist refuses services to a Member.

A. Wait Timeframes. Dentist must provide services to members within specified appointment timeframes that are applicable to regulatory requirements and benefits.

3.12 Member Hold Harmless Clause (as required by the State Board of Insurance). Dentist hereby agrees that in no event, including, but not limited to non-payment by FCL DENTAL, FCL DENTAL insolvency or breach of this agreement, shall Dentist bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than FCL DENTAL acting on their behalf for services provided pursuant to this Agreement and to the attached applicable Dental Plans. Dentist further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the FCL DENTAL Member, and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Dentist, Member or persons acting on their behalf.

Any modifications, addition, or deletion to the provisions of this section shall become effective on a date no earlier than 15 days after the Commissioner of Insurance has received written notice of such proposed changes.

3.13 Insurance. Dentist shall secure and maintain such policies of general and professional liability insurance as shall be necessary to insure Dentist, and his/her employees and other persons acting under his/her direction and control, against any liability, claim or claims for damages arising by reason of injury or death, occasioned directly or indirectly, in connection with the performance or nonperformance of any service by Dentist, his/her employees or other persons acting under his/her direction and control, under this Agreement. Dentist shall maintain minimum coverage limits for professional liability insurance of $100,000 per occurrence and $300,000 in the aggregate.

3.14 Evidence of Insurance. Dentist shall deliver to FCL DENTAL satisfactory evidence of such insurance coverage during each year of this agreement and shall further notify FCL DENTAL immediately of any and all substantial changes in or cancellation of said insurance coverage. The failure of Dentist to secure and maintain such professional liability insurance shall constitute a breach of this Agreement.

3.15 Indemnity. FCL DENTAL shall not be liable for any act or omission by Dentist or any of his/her personnel in connection with or arising solely out of the negligent performance of dental services by Dentist or any of his/her personnel with regard to FCL DENTAL Members. For such act or omission, Dentist agrees to defend, indemnify, and hold FCL DENTAL, its officers, agents, and employees, harmless from any claims, demands, liabilities, damages, losses, suits or judgments against any or all of those parties.

Dentist shall not be liable for any act or omission by FCL DENTAL or any of its personnel in connection with or arising solely out of the negligent performance of its responsibilities under the terms of this Agreement. For such act or omission, FCL DENTAL agrees to defend, indemnify, and hold Dentist and

employees, harmless from any claims, demands, liabilities, damages, losses, suits or judgments against any or all of those parties.

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

3.17 Clinical Laboratory. In the event Dentist has a need to use the services of a clinical laboratory for services rendered to a FCL DENTAL Medicaid/Medicare Member, then Dentist shall use a Medicare/Medicaid Certified Independent Laboratory or Medicare/Medicaid Certified Hospital Laboratory.

ARTICLE IV - DENTAL DIRECTORY; ELIGIBILITY INFORMATION

4.1 Dental Directory. FCL DENTAL agrees to list the Dentist and any affiliated dentists in its materials to Members, and Dentist hereby agrees to allow FCL DENTAL to so list them.

4.2 Eligibility of Members. Eligible Members will carry the appropriate membership identification; however, dentists can call FCL DENTAL to verify eligibility of Enrolled Members seeking dental services prior to beginning treatment. If the eligibility of a Member cannot be verified, Dentist can render treatment at Dentist's usual fees; provided, however, upon receipt of verification of coverage, and receipt of reimbursement from FCL DENTAL, Dentist shall reimburse Member the difference between the amount charged at the time of treatment and the amount which would have been due under Membership terms had eligibility been verified.

ARTICLE V - QUALITY ASSURANCE

5.1 Standards. Dentist agrees to perform services for Members with the same professional and ethical standards of care, skill, and diligence as generally promulgated by the American Dental Association and in accordance with the policies and procedures established by FCL DENTAL as noted within the FCL DENTAL provider manual.

5.2 Quality Assurance. FCL DENTAL, in consultation with its Dental Director, shall develop, implement and maintain a quality assurance program, policies and procedures and service standards. Dentist shall be bound by and comply with such policies and procedures and service standards as set forth in the Provider Manual.

Dentist hereby releases from liability all representatives of FCL DENTAL for their acts performed in good faith and without malice in connection with evaluating Dentist's practice and hereby releases from liability any and all individuals and organizations who provide information to FCL DENTAL.

ARTICLE VI - COMPENSATION

6.1 Applicable Dental Plans. This Agreement will provide for compensation to Dentist based on Dentist's agreement to provide services to FCL DENTAL Members. The compensation due Dentist will be based on each FCL DENTAL Plan under this Agreement. Specifications of each plan are attached.

6.2 Fees for Services. In exchange for the provision of services to Members, Dentist shall be due the amounts collectively shown in the provided Fee Schedule.

6.3 Payment. All FFS payments due and payable by FCL DENTAL under this Article VI (Compensation) shall be sent within the applicable State claim prompt payment requirement upon receipt of clean claim or FCL DENTAL shall notify Dentist in writing of reasons for denial of claim. Failure to report discrepancies with monthly FCL DENTAL data, if any, within one hundred twenty (120) days of receipt by Dentist shall signify to FCL DENTAL full agreement and acceptance thereof by Dentist.

A. FCL DENTAL will provide the Network Provider at least 90 days' notice prior to implementing a change in the claims guidelines, unless the change is required by statute or regulation in a shorter timeframe.

6.4 Prompt Payment. FCL DENTAL agrees to pay Provider in accordance with applicable Prompt Payment laws by state and product type for services provided to Plan Members. For purposes of this provision, a clean claim (see definition for additional clarity) shall mean a claim for Provider services that has no defect or impropriety requiring special treatment that prevents timely payment by FCL DENTAL.

6. 5 Coordination of Benefits. The value of any benefits or services provided under this Agreement may be coordinated with any other Third Party Administrator or coverage under governmental programs pursuant to the requirements of the State Insurance Code and rules promulgated by the State Board of Insurance and the Health and Human Service Commission.

6. 6 Co-payment Limits and Member Charges. Co-payment limits and member charges for noncovered services, no deductibles, or co- payments are permitted for covered services unless specified by plan design. Provider must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed private pay form from such a Member. Provider is responsible for collection at the time of service any applicable co-payments or deductibles in accordance with cost-sharing limitations. Co-payments and deductibles are the only amounts Providers may collect from Members except the costs associated with unauthorized non-emergency serviced provided to a Member by out-of- network providers for non-covered services. For purposes of this section noncovered services are services not covered under the plan, services which are provided in the absence of appropriate authorization and services which are provided out-of-network unless otherwise specified in the contract, policy or regulation.

ARTICLE VII - TERM AND TERMINATION OF AGREEMENT

7.1 Term. The effective date of this Agreement shall be the date first written above and have an initial term of 3 years. This Agreement shall continue in effect from year-to-year thereafter upon each and all of the terms and conditions herein contained, unless and until terminated as hereinafter provided.

7.2 Termination.

A. This Agreement may be terminated without cause by Dentist by written notice sent by registered or certified mail, at least 90 days in advance of the proposed termination date. Dentist's name will be removed from all future printings of FCL DENTAL materials, subsequent to the effective date of such notice. Prior to the effective date of any such notice and during that 90-day notice period, Dentist shall accept any and all new Members selecting Dentist, and shall provide treatment and services to all Members subject to the terms of this contract. FCL DENTAL may transfer Members subsequent to the termination notice and prior to the termination effective date, after so informing the Dentist.

B. FCL DENTAL may terminate this Agreement by written notice at least 90 days in advance of the effective date of termination, except in the case of imminent harm to patient health, action against license to practice, or fraud, in which case termination may be immediate.

C. Dentist shall have the right to terminate this Agreement immediately in the event FCL DENTAL ceases to hold a certificate of authority to operate as a single health care service plan under the Act and applicable State law.

D. FCL DENTAL may inactivate Dentist from further participation if FCL DENTAL determines that it needs to do so to investigate Dentist compliance with the terms of this Agreement.

E. Prior to termination FCL DENTAL will provide a written explanation to Dentist of the reason(s) for termination. Upon request and before the effective date of the termination, Dentist shall be entitled to a review of FCL DENTAL's proposed termination by the FCL DENTAL Peer Review Committee within a period not to exceed sixty (60) days, except in cases in which there is imminent harm to patient health, an action by a state dental licensing board or other governmental agency against the Dentist's license practice dentistry, or in cases of fraud. The Peer Review Committee shall include at least one representative in the Dentist's same or similar specialty. The decision of the Peer Review Committee will be made available to the Dentist and will be considered but will not be binding on FCL DENTAL.

7.3 Effect of Termination.

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

B. In the event of the termination of this Agreement, Dentist shall complete work started prior to the effective date of termination as follows:

1. If an impression has been taken, Dentist will complete a partial or denture.

2. On every tooth upon which work has been started.

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

4. If, at the time the Dentist receives notice of termination, the Dentist is treating a Member with Special Circumstances, then FCL DENTAL shall reimburse the Dentist at no less than the contract rate for that Member's dental care in exchange for continued treatment by that Dentist, unless the Dentist has been terminated due to a lack of dental competence or professional behavior. FCL DENTAL shall reimburse a terminated Dentist for ongoing treatment of Members with Special Circumstances for up to 90 days after the effective date of termination, or for up to 9 months in the case of a Member who has been diagnosed with a terminal illness at the time of termination. The treating Dentist is responsible for identifying Special Circumstances. The treating Dentist is responsible for requesting continued treatment under the Dentist's care. The treating Dentist is responsible for submitting disputes regarding the necessity of continued treatment to the FCL DENTAL advisory review panel.

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

D. In the event of termination of this Agreement for any reason, Dentist shall be paid any outstanding FFS payment as specified in this Agreement 60 days following the effective date of termination of this Agreement. FCL DENTAL shall be entitled to make any adjustments in such final payment as may be necessary as determined by FCL DENTAL.

E. Dentist agrees to notify Members who may continue to seek treatment from Dentist, subsequent to the Dentist's termination date, that Dentist is no longer a participating FCL DENTAL provider, prior to rendering any service. If such notice is not given to the Member, Dentist agrees to charge the Member no more for his/her services than would have been payable by the Member had this Agreement not terminated.

ARTICLE VIII - GENERAL PROVISIONS

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

8.2 Entire Agreement. This Agreement represents the entire understanding between the parties and supersedes any prior agreements or understandings with respect to the subject matter hereof. All

amendments or modifications hereto shall be mutually agreed to in writing by FCL DENTAL and Dentist, except as specified in Section 8.14.

8.3 Confidentiality. The Dentist agrees to keep confidential the terms and conditions of this participation Agreement.

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

8.5 Assignment. This Agreement shall not be assigned in whole or in part without the written consent of FCL DENTAL which consent shall not be unreasonably withheld.

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

8.7 Headings. The bold faced headings are for convenience and shall not affect interpretation.

8.8 Governing Law and Venue. This Agreement shall be construed and enforced in accordance with the laws of the applicable State governance , and shall have as its exclusive venue the State of Texas, County of Harris and City of Houston for legal proceedings of any kind that may arise by reason of this Agreement.

8.9 Compliance with Medicaid Plan's Obligations. Program violations arising out of performance of the contract are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG).

8.10 Financial Records. Dentist and FCL DENTAL shall cooperate in keeping financial and statistical records which may be necessary for the proper administration of FCL DENTAL or as required by state or federal laws and regulations. Such records shall be retained for a period of 5 years. Such obligations shall not terminate upon termination of this Agreement whether by rescission or otherwise.

8.11 Surcharges. Dentist is not permitted to surcharge any Member for covered services and shall, whenever a surcharge has erroneously occurred, upon notice by that Member or FCL DENTAL, refund such charge within 5 days.

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

8.13 Communications. Any written mass communication relating to FCL DENTAL or its Dental Plans (whether or not FCL DENTAL is specifically named) directed to Members by Dentist must be reviewed

and approved by FCL DENTAL prior to mailing. If Dentist fails to submit such communication to FCL DENTAL for prior approval, FCL DENTAL may terminate this Agreement immediately.

8.14 Retaliation. FCL DENTAL shall not retaliate against the Dentist because the Dentist has reasonably filed a complaint, on a Member's behalf, against FCL DENTAL. Retaliation includes cancellation of or refusal to renew a contract.

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

8.16 Additional Plans. FCL DENTAL may, from time to time, amend, delete or add to its various Dental Plans. In such an event, FCL DENTAL shall notify Dentist of these changes to reflect those amendments, deletions or additions. If Dentist does not accept such changes, Dentist shall notify FCL DENTAL in writing by registered or certified mail within 10 days of his/her receipt of such notification from FCL DENTAL and in such event, those Exhibits shall not become part of this Agreement. If Dentist does not accept such changes then FCL DENTAL has the right to terminate this Agreement, subject to ninety (90) days prior notice. If Dentist does not so notify FCL DENTAL, then those changes shall become part of this Agreement.

8.17 Medicare Advantage (MA) Plans. FCL DENTAL participates on various commercial and MA plans. Please see the Article X – Medicare Advantage Program Requirements for additional information regarding the specifics of an MA plan.

ARTICLE IX - MEDIATION

9.1 Dispute Resolution Process. It is the Agreement of the Parties to encourage the peaceable resolution of any disputes arising under this Agreement including the use of voluntary settlement procedures.

9.2 Mediation. In the event of any dispute, claim or controversy between the parties arising out of our relating to this Agreement, or any of the documents executed pursuant to this Agreement, whether in contract, tort, equity or otherwise, and whether relating to the meaning, interpretation, effect, validity, performance or controversy the parties agree to submit such controversy to mediation before a mediator duly qualified in accordance with the applicable State Statutes then in effect. In the event the parties cannot agree on a mediator, each party shall submit the name of two mediators, so qualified, and the four names shall be submitted to a sitting State District Court Judge in Harris County, Texas. Said judge may select from the list of four submitted names or may select a mediator not listed. Following selection of the mediator, the controversy shall be mediated by the parties within 30 days.

ARTICLE X - Medicare Advantage Program Requirements

The following language pertains only to plans designated as Medicare Advantage (MA) with respect to Members who are participants of those MA plans:

10.1 Books and Records; Governmental Audits and Inspections. Provider shall permit the Department of Health and Human Services ("HHS"), the Comptroller General, or their designees to inspect, evaluate and audit all books, records, contracts, documents, papers and accounts relating to Provider's performance of the Agreement and transactions related to the applicable regulatory agency contract (collectively, "Records"). The right of HHS, the Comptroller General or their designees to inspect, evaluate and audit Provider's Records for any particular contract period under the CMS Contract shall exist for a period of ten (10) years from the later to occur of (i) the final date of the contract period for the CMS Contract or (ii) the date of completion of the immediately preceding audit (if any) (the "Audit Period"). Provider shall keep and maintain accurate and complete Records throughout the term of the Agreement and the Audit Period.

10.2 Privacy and Confidentiality Safeguards. Provider shall safeguard the privacy and confidentiality of Members and shall ensure the accuracy of the health records of Members. Provider shall comply with all state and federal laws and regulations and administrative guidelines issued by CMS pertaining to the confidentiality, privacy, data security, data accuracy and/or transmission of personal, health, enrollment, financial and consumer information and/or medical records (including prescription records) of Members, including, but not limited, to the Standards for Privacy of Individually Identifiable Information promulgated pursuant to the Health Insurance Portability and Accountability Act.

10.3 Member Hold Harmless. Provider shall not, in any event (including, without limitation, non-payment by FCL DENTAL or breach of the Agreement), bill, charge, collect a deposit from, seek compensation or remuneration or reimbursement from or hold responsible, in any respect, any Member for any amount(s) that FCL DENTAL may owe to Provider for services performed by Provider under the Agreement. This provision shall not prohibit Provider from collecting supplemental charges, co-payments or deductibles specified in the Benefit Plans. Provider agrees that this provision shall be construed for the benefit of the Member and shall survive expiration, non-renewal or termination of the Agreement regardless of the cause for termination.

10.4 Delegation of Activities or Responsibilities. To the extent activities or responsibilities under a CMS Contract are delegated to Provider pursuant to the Agreement ("Delegated Activities"), Provider agrees that (i) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by the MA Plan ; and (ii) in the event that the MA Plan or CMS determine that Provider has not satisfactorily performed any Delegated Activity or responsibility thereof in accordance with the CMS Contract, applicable laws and regulations and CMS instructions, then the MA Plan shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Provider shall not further delegate any activities or requirements without the prior written consent of the MA Plan. To the extent that the Delegated Activities include professional credentialing services, Provider agrees that the credentials of medical professionals affiliated or contracted with Provider will either be (i) directly reviewed by the MA Plan, or (ii) Provider's credentialing process will be reviewed and approved by the MA Plan and the MA Plan shall audit Provider's credentialing process on an ongoing basis.

Provider acknowledges that the MA Plan retains the right to approve, suspend or terminate any medical professionals, as well as any arrangement regarding the credentialing of medical professionals.

10.6 Reporting Requirements. Provider must have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information with respect to the following:

(1) The cost of its operations.
(2) The patterns of utilization of its services.
(3) The availability, accessibility, and acceptability of its services.
(4) To the extent practical, developments in the health status of its enrollees.
(5) Information demonstrating that the MA organization has a fiscally sound operation.
(6) Other matters that CMS may require if Provider generates any data submitted to CMS by MA Plan, upon MA Plan's request, Provider shall certify (based on Provider's best knowledge, information and belief) the accuracy, completeness and truthfulness of the data.

10.7 Compliance with MA Plan's Obligations, Provider Manual, Policies and Procedures.
Provider shall perform all services under the Agreement in a manner that is consistent and compliant with MA Plan's contract(s) with CMS (the "CMS Contract"). Additionally, Provider agrees to comply with the MA Plan Provider Manual and all policies and procedures relating to MA Benefit Plans.

10.8 Subcontracting. The MA plan maintains ultimate accountability for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of MA Plan. Every subcontract between Provider and a subcontractor shall (i) be in writing and comply with all applicable local, State and federal laws and regulations; (ii) be consistent with the terms and conditions of this Agreement; (iii) contain the MA Plan and Member hold harmless language as set forth in Section 3 hereof; (iv) contain a provision allowing MA Plan and/or its designee access to such subcontractor's books and records as necessary to verify the nature and extent of the Covered Services furnished and the payment provided by Provider to subcontractor under such subcontract; and (v) be terminable with respect to Members or Benefit Plans upon request of MA Plan.

10.9 Compliance with Laws. Provider shall comply with all laws, regulations and instructions from CMS applicable to Provider's performance of services under the Agreement. Provider shall maintain all licenses, permits and qualifications required under applicable laws and regulations for Provider to perform the services under the Agreement. Without limiting the above, Provider shall comply with Federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (section 1128B(b) of the Social Security Act).

10.10 Program Integrity. Provider represents and warrants that Provider (or any of its staff) is not and has not been (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities.

Provider shall notify FCL DENTAL immediately if, at any time during the term of the Agreement, Provider (or any of its staff) is (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities.

Provider acknowledges that Provider's participation in the MA Plans shall be terminated if Provider (or any of its staff) is debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services.

10.11 Continuation of Benefits. Provider shall continue to provide services under the Agreement to Members in the event of (i) MA Plan's or FCL DENTAL's insolvency, (ii) MA Plan's or FCL DENTAL discontinuation of operations or (iii) termination of the CMS Contract, throughout the period for which CMS payments have been made to MA Plan, and, to the extent applicable, for Members who are hospitalized, until such time as the Member is appropriately discharged.

10.12 Incorporation of Other Legal Requirements. Any provisions now or hereafter required to be included in the Agreement by applicable Federal or state laws and regulations or by CMS shall be binding upon and enforceable against the parties to the Agreement and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in the this Addendum or elsewhere in the Agreement.

10.13 Provider Incentive Plans. The MA organization makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. To the extent that an incentive plan is administered for services provided by providers under an agreement, the provider/physician incentive plan shall meet the requirements of CMS 42 CFR, §§422.208, where and if applicable.

10.14 Hold Harmless of Dual Eligible Members. With respect to those members who are designated as Dual Eligible Members for whom the State Medicaid agency is otherwise required by law, and/or voluntarily has assumed responsibility in the State Medicaid Plan to cover those Medicare Part A and B Member Expenses identified and at the amounts provided for in the State Medicaid Plan, Provider acknowledges and agrees that it shall not bill Members the balance of ("balance-bill"), and that such Members are not liable for, such Medicare Part A and B Member Expenses, regardless of whether the amount Provider receives is less than the allowed Medicare amount or Provider charges due to limitations on additional reimbursement provided in the State Medicaid Plan. Provider agrees that it will accept Health Plan's payment as payment in full or will bill the appropriate State source if Health Plan has not assumed the State's financial responsibility under an agreement between Health Plan and the State. [42 C.F.R. § 422.504(g)(1)(iii)]. FCL DENTAL shall inform providers of Medicare and Medicaid benefits and rules for Members eligible for Medicare and Medicaid.

ARTICLE XI - NOTICES

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

A. To: FCL DENTAL
101 Parklane Boulevard, Suite 301
Sugar Land, Texas 77478

B. To Dentist, it shall be addressed as indicated in the Application.

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

IN WITNESS WHEREOF the parties have duly executed this Agreement on the day and year first written above.

Dentist Signature: _____

DATE: _____

NAME: _____

Individual NPI #: _____
(Print)

FOR INTERNAL USE ONLY

First Continental Life and Accident Insurance Company (FCL DENTAL)

BY: _____

TITLE: _____

DATE: _____

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

☐ Exempt payee

☐ Other (see instructions) ▶

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

Purpose of Form

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

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

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

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

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

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

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

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

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

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

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

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

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

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

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

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

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

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

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

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

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

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

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

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

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

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

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

Specific Instructions

Name

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

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

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

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

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

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/ disregarded entity name," sign and date the form.

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

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

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

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

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt payees 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

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

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

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

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

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

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

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

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

Part II. Certification

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

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

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

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

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

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

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

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

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

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

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

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

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

Secure Your Tax Records from Identity Theft

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

To reduce your risk:

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

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

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

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

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

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

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.