PROVIDER APPLICATION

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.

Provider Name:_____ NPI# _____

PLAN ELECTION SECTION:

The dental plan options are listed below. Please choose the plan(s) in which you are interested in participating (Your application may be delayed if all boxes that apply are not checked off):

FCL DENTAL / PDP
(Any State Licensed To Do Business In)

- ☐ FCL PDP (Provider Dental Plans)

FCL DENTAL (Texas Only)

- ☐ OraQuest Dental Plan - Dental HMO
- ☐ Kelsey Care Advantage (Medicare Advantage)
- ☐ Texas Children's Health Plan CAP Plan (Adult Medicaid)
- ☐ Community Health Choice CAP Plan (Adult Medicaid)
- ☐ Community Health Choice (DSNP)

FCL DENTAL / DENTAL SOURCE
(Kansas and Missouri Only)

- ☐ Dental Source - Dental HMO Plan E
- ☐ Dental Source - Dental HMO Plan H
- ☐ Free Access Plan (FAP)
- ☐ Safeguard

FCL DENTAL / DENTAL SOLUTIONS PLUS
(Tennessee and Mississippi Only)

- ☐ Dental Solutions Plus Discount Plan

DINA / GUARANTY ASSURANCE (Louisiana Only)

- ☐ DINA PPO
- ☐ DINA Pre-Paid
- ☐ Ochsner Health Plan (Medicare Advantage)

MEDICARE / MEDICAID PLANS
(Any State Licensed To Do Business In)

- ☐ Medicare Plans
- ☐ Medicaid Plans (CAP Plan)

OPT OUT OF ZELIS / THIRD PARTY COMPANIES

- ☐ Yes
- ☐ No

Fill out the application materials to join our networks and return them to us. Be sure to include copies of appropriate licenses and certifications as indicated on the application. Additional documentation may be sent to and/or requested from you.

Your application materials will be reviewed and, if you are accepted as a participating dentist, you will receive notification from us welcoming you into our network.

We look forward to your participation. If you have any questions about which plans are in your state or need additional forms, please call the Dentist Provider line at **1-877-493-6282** from 8 a.m. – 5 p.m. ET, Monday – Friday or email us at pr@fcldental.com.

ITEMS REQUIRED FOR PROVIDER APPLICATION TO BE CONSIDERED:

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

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

Texas Standardized Credentialing Application

(Please type or print)

Section I-Individual Information

TYPE OF PROFESSIONAL

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

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

HOME MAILING ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

HOME PHONE NUMBER	SOCIAL SECURITY NUMBER	☐ Female ☐ Male

CORRESPONDENCE ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

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

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

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

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

Education

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

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

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

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

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

INSTITUTION

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

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

PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)

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

INSTITUTION

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

Education - *continued*

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

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

OTHER GRADUATE-LEVEL EDUCATION
Issuing Institution:

ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	

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

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

UPIN	NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE)
ARE YOU A PARTICIPATING MEDICARE PROVIDER? ☐ Yes ☐ No Medicare Provider Number:	ARE YOU A PARTICIPATING MEDICAID PROVIDER? ☐ Yes ☐ No Medicaid Provider Number:

EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) ☐ N/A ☐ Yes ☐ No ECFMG Number:	ECFMG ISSUE DATE (MM/DD/YYYY)

Professional/Specialty Information

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

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

☐ I have taken exam, results pending for Board.

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

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

☐ I am not planning to take Boards.

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

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

Professional/Specialty Information *-continued*

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

☐ I have taken exam, results pending for Board.

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

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

☐ I am not planning to take Boards.

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

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

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

☐ I have taken exam, results pending for Board.

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

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

☐ I am not planning to take Boards.

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

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

Work History

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

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

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

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

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

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

Gap Dates: Explanation:

Gap Dates: Explanation:

Work History – *continued*

Gap Dates: Explanation:

Gap Dates: Explanation:

☐ *Please check this box and complete and submit Attachment C if you have additional work history*

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

DO YOU HAVE HOSPITAL PRIVILEGES? ☐ Yes ☐ No	IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE?	
PRIMARY HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?		
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		

☐ *Please check this box and complete and submit Attachment D if you have additional <u>current</u> hospital affiliations.*

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		

☐ *Please check this box and complete and submit Attachment E if you have additional <u>previous</u> hospital affiliations.*

References-*Please provide three peer references from the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of your abilities.*

1 NAME/TITLE	PHONE NUMBER
ADDRESS	
CITY	STATE/COUNTRY POSTAL CODE

References- *continued*

2 NAME/TITLE		PHONE NUMBER
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE

3 NAME/TITLE		PHONE NUMBER
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE

Professional Liability Insurance Coverage

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

Call Coverage

☐ See attached list of hospital staff within my department I utilize for call coverage.

PLEASE LIST NAMES OF COLLEAGUE(S) PROVIDING REGULAR COVERAGE AND HIS OR HER SPECIALTIES.

Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:

PLEASE LIST FULL NAMES OF ALL PARTNERS IN YOUR PRACTICE. ☐ CHECK THIS BOX AND ATTACH LIST FOR LARGE GROUP.

Name:	Name:
Name:	Name:
Name:	Name:
Name:	Name:

Practice Location Information - *Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.*

PRACTICE LOCATION of

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

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9

PRACTICE LOCATION ADDRESS ☐ **Primary**

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER

GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER

ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ☐ Yes ☐ No	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ☐ Yes ☐ No

OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER

CREDENTIALING CONTACT

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BILLING COMPANY'S NAME (IF APPLICABLE)	BILLING REPRESENTATIVE

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

DEPARTMENT NAME IF HOSPITAL-BASED	CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY? ☐ Yes ☐ No

HOURS PATIENTS ARE SEEN

Monday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Tuesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Wednesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Thursday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Friday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Saturday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Sunday	☐ No Office Hours	Morning:	Afternoon:	Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?
☐ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS
☐ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS
☐ Male only ☐ Female only Age: ☐ Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?
☐ Yes ☐ No If yes, provide the following information for each staff member:

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

Practice Location Information - continued

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

ARE INTERPRETERS AVAILABLE?
☐ Yes ☐ No If yes, please specify languages:

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?
☐ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
☐ Building ☐ Parking ☐ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☐ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☐ Bus ☐ Regional Train ☐ Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?
☐ Yes ☐ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☐ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support	☐ Staff	☐ Provider Exp:	Advanced Life Support in OB	☐ Staff	☐ Provider Exp:
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp:	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp:
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp:	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp:
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp:	Other (please specify)	☐ Staff	☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No

☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No

☐ X-ray; please list all certifications:

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration /Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies
☐ Other:			

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?
☐ Yes ☐ No Please specify the classes or categories:

WHO ADMINISTERS IT?

☐ Please *check this box and complete and submit Attachment F if you have other practice locations.*

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

Licensure

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Hospital Privileges and Other Affiliations

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Education, Training and Board Certification

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

DEA or DPS

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

☐ Yes ☐ No

Medicare, Medicaid or other Governmental Program Participation

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

☐ Yes ☐ No

Other Sanctions or Investigations

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

☐ Yes ☐ No

Section II - Disclosure Questions - *continued*

Other Sanctions or Investigations

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Malpractice Claims History

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

☐ Yes ☐ No

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

Criminal

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Ability to Perform Job

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Ability to Perform Job

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

Section II - Disclosure Questions-*continued*

Please use the space below to explain yes answers to any question except 16.

QUESTION NUMBER	PLEASE EXPLAIN

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

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

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

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

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

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

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

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

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

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

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

Section III – Standard Authorization, Attestation and Release – continued

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

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

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

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

SIGNATURE

NAME (PLEASE PRINT OR TYPE)

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

DATE (MM/DD/YYYY)

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

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

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

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

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

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

INSTITUTION

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

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

PROGRAM DIRECTOR
CURRENT PROGRAM DIRECTOR (IF KNOWN)

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

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ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

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CURRENT PROGRAM DIRECTOR (IF KNOWN)

OTHER POST-GRADUATE EDUCATION SPECIALTY
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INSTITUTION

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

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

PROGRAM DIRECTOR
CURRENT PROGRAM DIRECTOR (IF KNOWN)

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

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ *Yes* ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ *Yes* ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ *Yes* ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ *Yes* ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		
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ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
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ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
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OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		
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ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
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OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ *Yes* ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ *Yes* ☐ No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ *Yes* ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ *Yes* ☐ No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ *Yes* ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ *Yes* ☐ No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
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REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ *Yes* ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ *Yes* ☐ No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ *Yes* ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ *Yes* ☐ No
REASON FOR DISCONTINUANCE		

Practice Location Information - *Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.*

PRACTICE LOCATION of

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

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9

PRACTICE LOCATION ADDRESS ☐ **Primary**

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER

GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER

ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ☐ Yes ☐ No	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ☐ Yes ☐ No

OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER

CREDENTIALING CONTACT

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BILLING COMPANY'S NAME (IF APPLICABLE)	BILLING REPRESENTATIVE

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

DEPARTMENT NAME IF HOSPITAL-BASED	CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY? ☐ Yes ☐ No

HOURS PATIENTS ARE SEEN

Monday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Tuesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Wednesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Thursday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Friday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Saturday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Sunday	☐ No Office Hours	Morning:	Afternoon:	Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?
☐ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS
☐ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS
☐ Male only ☐ Female only Age: ☐ Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?
☐ Yes ☐ No If yes, provide the following information for each staff member:

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER

Practice Location Information - continued

NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE
NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE
NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE
NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

ARE INTERPRETERS AVAILABLE?
☐ Yes ☐ No If yes, please specify languages:

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?
☐ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
☐ Building ☐ Parking ☐ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☐ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☐ Bus ☐ Regional Train ☐ Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?
☐ Yes ☐ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☐ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support	☐ Staff	☐ Provider Exp:	Advanced Life Support in OB	☐ Staff	☐ Provider Exp:
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp:	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp:
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp:	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp:
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp:	Other (please specify)	☐ Staff	☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No
☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No
☐ X-ray; please list all certifications:

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration /Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies
☐ Other:			

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?
☐ Yes ☐ No Please specify the classes or categories:

WHO ADMINISTERS IT?

☐ Please *check this box and complete and submit Attachment F if you have other practice locations.*

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

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

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.