DELTA DENTAL®

New Member Application Checklist

Specialists

Thank you for choosing to become a member of Delta Dental of Tennessee (DDTN).
To avoid delay in processing your application, please make sure all of the items below are included when mailing, emailing or faxing your application.

- ☐ Completed Credentialing Profile
- ☐ Completed and Signed Delta Dental Premier/Delta Dental PPO (PPO) Specialist Agreement
- ☐ W-9 Form – completed and signed indicating the Tax Identification Number (TIN) you report to the Internal Revenue Service. (This will be the TIN used when filing claim forms). ***Note: A W-9 form must be submitted for each location.***

Submit above correspondence to:

Delta Dental of Tennessee
Attn: Professional Relations Dept.
240 Venture Circle
Nashville TN 37228
Fax (615) 742-6940 or Email: cbruce@deltadentaltn.com

DELTA DENTAL

CONFIDENTIAL CREDENTIALING INFORMATION FORM

This form must be completed by the contracting dentist. Your responses on this form will be used to determine whether you meet the eligibility criteria for participation in the network. Treating dentists must maintain eligibility throughout the term of their participation.

1. Provider Information

Last Name: ____________ First Name: ____________ Middle Initial: ______

Other name used: ____________

❑ DDS ❑ DMD ❑ Other ____________ ❑ Individual NPI Number: ____________

Date of Birth: ____________ (DOB is mandatory) ❑ Male ❑ Female ❑ Dentist Social Security # ____________ (SS# is mandatory here not Tax ID or NPI)

Dental School: ____________ Month/Year Graduated: ____________

Specialty School (if applicable): ____________ Month/Year Graduated: ____________

❑ General Dentist ❑ Orthodontist ❑ Oral Surgeon ❑ Prosthodontist

❑ Pedodontist ❑ Endodontist ❑ Periodontist

Are you currently American Board Certified? ❑ Yes ❑ No If yes, indicate which Specialty Board: ____________

List hospital for which you have privileges: (List any additional hospitals on back.)

Name: ____________ Address: ____________

Copies of the following documents are required - Copies must be clear, legible and current.

Dental License #: ____________ State: ______ Exp. Date: ____________

Additional Dental License #: ____________ State: ______ Exp. Date: ____________

DEA Certificate #: ____________ DEA Exp. Date: ____________

Do you have a current license or permit to administer conscious sedation / general anesthesia? ❑ Yes ❑ No ❑ N/A

Type: ❑ IV Sedation ❑ General Anesthesia Permit #: ____________ Exp. Date: ____________

Prof. Liability Ins. Co.: ____________ Policy #: ____________

Liability Limits: *(Each Claim)* ____________ *(Aggregate Claim)* ____________ Policy Exp. Date: ____________

Practice Name: ____________ **Start Date**: ____________ (Month/Year)

Practice Address: ____________

City: ____________ State: ______ Zip: ____________

Business NPI Number: ____________ TIN #: ____________

Office Contact Person: ____________ Office Email: ____________

Office Phone: ____________ Office Fax Number: ____________

If applicable:

Controlled Substance Certificate #: ____________ Exp. Date: ____________

Please provide your state issued Medicaid number: ____________

2. Dental Work History for the Past Five Years

Dentist Name	Dentist License Number	State Issuing License

You must list a complete work history for the past five years including dates. Please provide an explanation of any work gaps greater than six months during the past five (5) years. If you have fewer than five (5) years of work history, please include your initial licensing date.

	Practice/Group Name	Month/Year	Month/Year
1.	______________________	**Start Date:**________	**End Date:**________
2.	______________________	**Start Date:**________	**End Date:**________
3.	______________________	**Start Date:**________	**End Date:**________

Explanation of gaps of six months or more:

Time Period
Start Date: **End Date:**

______________________________ ______________

______________________________ ______________

3. Provider Checklist

Please note, we must receive the following documents from you in order to process your application:

- ❑ A complete copy of this form (*"Credentialing Information Form"*)
- ❑ A copy of each dentist's DEA certificate (if applicable) with a future expiration date
- ❑ A copy of the declaration page /certificate of coverage of each dentist's malpractice insurance with a future expiration date

Date Stamp

Return this form to:
Delta Dental of Tennessee
Professional Relations Dept. 240
Venture Circle
Nashville TN 37228
Fax: 615-742-6940
Email: cbruce@deltadentaltn.com

TO EXPEDITE THE CREDENTIALING PROCESS, THIS PAGE MUST BE COMPLETED IN ITS ENTIRETY.

4. Professional Attestation and Questions

Dentist First Name (Please print)	Middle Initial	Last Name

Dentist Date of Birth	Dentist License Number	State Issuing License

I. Credentialing History (Please answer questions 1 - 10 below. For any "Yes" answer, explain on a separate piece of paper.)

Yes	No		
❑	❑	1.	Has your license to practice in any jurisdiction, whether past or still pending, been denied, restricted, limited, suspended, revoked, not renewed, placed under probation, subjected to disciplinary action, or otherwise sanctioned, limited or curtailed?
❑	❑	2.	Has your professional liability insurance ever been denied, suspended, revoked, canceled, or not renewed?
❑	❑	3.	Has your Federal and/or State DEA license or applicable drug license ever been denied, suspended, canceled or not renewed, or subjected to any disciplinary action?
❑	❑	4.	Has your status as a provider ever been denied, suspended, canceled or sanctioned by any municipal, state, federal or any other governmental agency (e.g. Medicare, Medicaid, OIG or Denti-Cal) HMO, EPO, PPO or other prepaid health plan?
❑	❑	5.	Are your privileges or memberships at any hospital, institution (Military service) and/or HMO currently under investigation or have they ever been denied, suspended, reduced or not renewed?
❑	❑	6.	Have you ever been denied membership, or renewal of membership, or been subject to disciplinary proceedings for a medical, dental or ethical reason by any dental/professional organization?
❑	❑	7.	Are you unable to perform any procedures within the scope of privileges and duties in your position as a health care provider, with or without reasonable accommodations required by the Americans With Disabilities Act, within accepted standards of professional performance and without posing a direct threat to patients?
❑	❑	8.	Do you currently, or did you in the last five years, engage in the unlawful use of illegal drugs, including improper use of prescription drugs?
❑	❑	9.	Do you have any felony or misdemeanor charges pending against you or have you ever been convicted of a felony, or pleaded "nolo contendere" to a felony?
❑	❑	10.	Have you been involved in ANY malpractice (or any other civil) claims/lawsuits, settlements or judgments within the last **five years? If yes, please provide detailed information on a separate sheet of paper including: docket number of the case, location of the court, names of the parties, plaintiff(s) and defendant(s), dates of the incident(s), description of the incident(s), your involvement, current disposition, and the amount of the settlement(s)**.

II. Compliance & Malpractice Insurance (Answer questions 11, 12 and 13. For any "NO" answer, explain on a separate sheet of paper.)

Yes	No		
❑	❑	11.	Do you follow Center for Disease Control Guidelines for Infection Control in Dental Health-Care Settings and observe all applicable laws and regulations related to the practice of dentistry including, but not limited to, those dealing with infection control and employee safety in the work place?
❑	❑	12.	Do you have current professional malpractice insurance coverage and agree to maintain continuous, uninterrupted coverage while either a contracted dental provider for the Plan or an associate of a contracted dental provider? Please note that under the terms of participation that you further agree to notify the Plan immediately of any policy cancellation, lapse in coverage, reduction in coverage maximum(s) or claims made.
❑	❑	13.	Is practice accepting new patients?

I authorize the Plan to consult with professional liability carriers, and other persons or entities to obtain information concerning my professional qualifications including competence, ethics and other qualifications. I, the undersigned, hereby certify that the information requested by the Plan and provided herein, is truthful, correct and complete in all respects. I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for denying participation or termination as a contracting dentist with the dental plan. The undersigned hereby agrees to notify the Plan immediately of any changes in the above information.

Upon request, practitioners have the right to review the information in their credentialing file and to ask for correction of any error or omission believed to be significant. To be accepted, any such requests must be submitted in writing to the Provider Administration department within 365 days of the practitioner's last submission of completed credentialing forms. Practitioners have the right to submit a written appeal to refute the basis for any adverse action by the Plan based on credentialing eligibility criteria. The time period in which to submit a written appeal is subject to state requirements and the provider agreement. If the adverse action decision is upheld upon appeal, practitioners may request a hearing before a hearing panel.

Dentist Signature (no signature stamps): ______________________ Date: ______________

RULES AND REGULATIONS OF DELTA DENTAL OF TENNESSEE

(Revision January 29, 1994)
(Revision October 2, 1998)
(Revision December 13, 1998)
(Revision May 4, 2001)
(Revision August 4, 2001)
(Revision August 31, 2006)
(Revision March 21, 2014)
(Revision November 2, 2020)

(1) A participating dentist agrees to abide by the Rules and Regulations as established by Delta Dental of Tennessee (DDTN) as well as any others which may be adopted from time to time by the DDTN Board of Directors. Any violation of these Rules and Regulations may result in the revocation of the Dentist's Participating Agreement.

(2) Under the Rules and Regulations, the contract between DDTN and the participating dentist shall consist of, but not be limited to, the following:

The Participating Dentist Agreement
The Rules and Regulations
The provisions of DDTN's group contracts and/or agreements with group purchasers, and their Processing Policies used in determining benefits.

(3) A participating dentist's charges, including deductibles and/or co-payments, allowed by DDTN for dental services, shall be the lesser of the dentist's submitted fee or the Maximum Plan Allowance (MPA) established by DDTN to administer Delta Dental pre-paid dental care programs. These programs include Delta Dental National Accounts and DeltaUSA Accounts.

(4) A participating dentist shall charge and make reasonable efforts to collect all applicable deductibles and/or co-payments from DDTN patients.

(5) A participating dentist shall not receive payment from a DDTN patient for any portion of a billing which is to be paid by DDTN or its agent.

The exception to this is that a participating dentist may request payment in advance for services that will be covered by DDTN for services performed on a patient's first visit to the dentist's office where the dentist has been unable to confirm the patient's eligibility prior to treatment.

Prepayment, interest or service charges may not be charged on that portion of the fee for which DDTN is responsible.

(6) A participating dentist may offer services at less than the fee she/he would normally submit to DDTN for payment provided:

(A) The discount is a legitimate professional discount offered to an identifiable segment of the dentist's practice;

(B) The lower fee is accorded to DDTN; and

(C) Records are maintained by the dentist to verify compliance.

(7) A participating dentist may not submit or cause to be submitted to DDTN any Attending Dentist's Statement or any other statement which contains untrue or misrepresented information.

(8) A participating dentist may not sign an Attending Dentist's Statement which includes services rendered by another dentist.

(9) A participating dentist who renders services to any DDTN patient shall be fully and totally responsible for all related information provided to DDTN on any Attending Dentist's Statement whether that dentist is a solo practitioner, a partner in a partnership, or a member, principal, agent, employee or affiliate of a professional or other corporation or dental practice. Any liability arising out of any payment made on behalf of or at the request of a participating dentist should be and remains that of the dentist.

(10) A participating dentist shall schedule patients and provide dental treatment in accordance with applicable standards of the dental profession and without regard to whether that patient is eligible for dental expense benefits, i.e., the necessary and method of care is to be determined solely by professional standards.

(11) A participating dentist agrees to cooperate with peer review committee and/or consultant designated by DDTN to review professional standards relative to care provided by the participating dentist. The decision of any such consultant or committee, subject to any applicable appeal process, shall be binding on that participating dentist and DDTN.

(12) A participating dentist agrees that DDTN may withhold a portion of its payment to a dentist for development of the corporation ("Research and Development Withhold"). This withhold, as well as any other DDTN reductions to any fees submitted on an Attending Dentist's Statement, may not by charged back to the patient unless approved by DDTN.

(13) In order for DDTN to determine compliance with the Participating Dentist Agreement, the dentist agrees to maintain and make available adequate records for random review or for cause. The dentist will make available upon request to a representative of DDTN at the office where treatment was rendered and at reasonable times, all books, records, papers, and computer systems related to treatment and charges to any of the dentist's patients and in sufficient quantity as determined by DDTN, to verify and/or re-verify compliance with the Rules and Regulations. Records covering payments received for services, regardless of source and/or method shall also be made available without charge.

(14) A participating dentist agrees to file primary, secondary, or pre-determination claim forms for DDTN subscribers at no charge to DDTN or the subscribers.

(15) A participating dentist agrees that s/he is a partner in a partnership, or a member, principal, agent, employee or affiliate of a professional or other corporation or dental practice, all other partners, members, principals, agents, employees or affiliates must be members of DDTN.

(16) A participating dentist agrees s/he will accept for his/her services performed pursuant to this contract, the benefit payments determined by DDTN, and shall make no charge to an eligible subscriber, which is contrary to the dentist payment contracts negotiated by DDTN.

(17) A participating dentist agrees to allow for random review or for cause, either pre or post-operative examinations of his/her patients who are DDTN subscribers if necessary to determine benefits or to assure compliance with the Participating Dentist Agreement.

(18) A participating dentist, who is found to have violated the Rules and Regulations, singly or in combination, shall be deemed to be in noncompliance with his/her Participating Dentist Agreement and shall be sanctioned in accordance with the Bylaws of DDTN.

(19) A dentist, who has lost his /her participating status, after complying with any and all conditions of a sanction, may apply for reinstatement in accordance with the Bylaws of DDTN.

(20) A participating dentist shall not be relieved of any obligation incurred under his/ her Participating Dentist Agreement regardless of any subsequent termination of participating status. Any procedures or restorations begun prior to termination shall be completed under the contracted Participating Agreement.

(21) A participating dentist authorizes DDTN to deduct from any payments due him/her such sums as DDTN reasonably determines to be properly due and owing to DDTN as a refund of payments incorrectly made to or claimed by the dentist for which the dentist has not refunded the amount due.

(22) Any dentist terminated in any DDTN program will be terminated in all DDTN programs.

(23) Participating dentists are required to maintain Professional Liability Insurance in an amount established by DDTN and to provide evidence of such to DDTN in a manner it describes.

(24) A participating dentist agrees to comply with all governmental regulations issued by both State and Federal agencies.

DELTA DENTAL

Specialist Agreement

Delta Dental Premier and Delta Dental PPO

Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228

I represent that I am duly licensed to practice dentistry in the State of Tennessee, having been issued License Number ____________________ by the Tennessee Board of Dental Examiners; that my license is in good standing; and, that no disciplinary proceedings are pending against me.

I hereby apply for membership in Delta Dental of Tennessee (DDTN) (a non-profit Tennessee Corporation) as a Participating Dentist in its Delta Dental Premier **and** Delta Dental PPO Programs, including Delta Dental National Accounts and DeltaUSA.

In consideration of this membership, I agree:

1. That I will be bound by the Bylaws, and Rules and Regulations of DDTN, including any future amendments thereto, following notification from DDTN.
2. That I will maintain my license in good standing.
3. That I understand that DDTN utilizes a Maximum Plan Allowance (MPA) fee concept with deductibles, co-payments or coinsurance features to administer prepaid dental care programs. As a Participating Dentist, I agree to accept the lesser of my submitted fee or MPA fee as payment in full for services rendered to any DDTN/DeltaUSA enrollee and will not bill for any difference above the amount indicated on the remittance information as patient's responsibility. All payments will be made by Electronic Funds Transfer (EFT).
4. That I will render dental service to eligible subscribers and their covered dependents without discrimination because of their DDTN eligibility and with the same high standards of dental care provided to all my patients. Included are subscribers and covered dependents of Delta Dental National Accounts and DeltaUSA Accounts.
5. That I will maintain patient treatment records and in order to assure compliance with the requirements of DDTN, I will furnish, upon request, such records or reports for random review or for cause as may be deemed necessary at no charge during regular DDTN business hours. Information not required to assure compliance may be concealed to protect patient confidentiality.
6. That in rendering dental service under this Agreement, I will be acting as an independent contractor and not as an agent or employee of DDTN. DDTN shall not be held liable for any wrongful act on my part. I agree to indemnify and hold harmless DDTN with respect to any damages, costs, judgments, claims or other liabilities resulting from any acts or omissions on my part, in accordance with TCA 56-2-124.
7. That my rights, privileges, duties and obligations hereunder are not assignable. I understand that this agreement may be terminated by either party by not less than thirty (30) days written notice to the other party. Such right on the part of DDTN to be exercised only by action of its Executive Committee or the Board of Directors.
8. That my office meets all requirements of the State and Federal regulatory agencies.
9. That I will maintain Professional Liability Insurance as required by DDTN and to immediately notify DDTN in the event of any insurance changes.
10. That I have read the Bylaws, and Rules and Regulations of DDTN.
11. That I understand this agreement does not become effective until duly accepted by DDTN and that upon acceptance, I shall be a participating member of DDTN.acceptance, I shall be a participating member of DDTN.

Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228

Specialist Agreement

Delta Dental Premier and Delta Dental PPO

Dentist Signature ______________________ Date ______________

Dentist Name (printed) ______________________ License Number ______________

Diplomat, Board of (if any) ______________________ Taxpayer Identification Number ______________

Primary Office Street Address ______________________

City ______________________ State ________ Zip Code ______________

Telephone ______________

This application for appointment as a Participating Dentist in the DDTN Specialist Program is hereby accepted and the above named applicant is entitled to all rights and privileges of a Participating Dentist.

Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228-1669

By: ______________________ ______________
President & CEO of Delta Dental of Tennessee Date

Form **W-9**
(Rev. August 2013)
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) ▶ ________

☐ Other (see instructions) ▶

Exemptions (see instructions):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

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

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

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

General Instructions

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

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

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, payments made to you in settlement of payment card and third party network transactions, 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, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and 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 under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 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 section 1446 withholding on your share of partnership income.