DELTA DENTAL

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PARTICIPATING DENTIST'S DENTAL WELLNESS PLAN AGREEMENT

This Participating Dentist's Dental Wellness Plan Agreement (this **"Agreement"**) is made by and between Delta Dental of Iowa, an Iowa not-for-profit corporation (**"Delta Dental"**), and the undersigned individual licensed to engage in the practice of dentistry in the State of Iowa in accordance with Chapter 153 of the Iowa Code (**"Participating Dentist"**) and shall be effective as of the date accepted by Delta Dental.

RECITALS:

A. Delta Dental has entered into or anticipates entering into an agreement with the State of Iowa acting by and through the Iowa Department of Human Services to administer certain dental benefits to Covered Enrollees (as such term is defined below).

B. Participating Dentist wishes to enter into this Agreement to provide dental services to Covered Enrollees.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

1. Defined Terms. The following terms shall have the following meanings when used in this Agreement:

   (a) **"Covered Enrollee"** means an individual eligible to receive dental services under the Iowa Health and Wellness Plan Contract through Delta Dental.

   (b) **"Covered Services"** means dental services that meet both of the following requirements: (i) a Covered Enrollee is eligible to receive the dental services under the Dental Wellness Plan Prepaid Ambulatory Health Plan (PAHP) Contract; and (ii) Participating Dentist is entitled to payment for the dental services under the terms and conditions of this Agreement.

   (c) **"Dental Wellness Plan PAHP Contract"** means the "Contract for Dental Care Services" between the State of Iowa acting by and through the Iowa Department of Human Services and Delta Dental of Iowa, as the same may be amended or restated from time to time.

2. Entire Agreement; Applicability. This Agreement, together with the Incorporated Documents (as defined below), constitute the complete agreement between Participating Dentist and Delta Dental concerning the Dental Wellness Plan product and supersede all negotiations, preliminary agreements and all prior or contemporaneous discussions and understandings between them in connection with the subject matters hereof. All of the Incorporated Documents are incorporated into this Agreement as if set forth in their entirety and constitute a part hereof. This Agreement applies only to

the Dental Wellness Plan product. This Agreement does not apply to any other product of Delta Dental, including, without limitation, any product described in any Delta Dental Premier Participating Dentist's Agreement, any Delta Dental PPO Agreement Supplement to any Delta Dental Premier Participating Dentist's Agreement or any Delta Dental Participating *hawk-i* Orthodontic Services Agreement that may now or hereafter be in effect between Delta Dental and Participating Dentist from time to time, and any such agreement shall be unmodified by this Agreement and shall remain in full force and effect. This Agreement shall only be effective if Delta Dental enters into Dental Wellness Plan PAHP Contract. If Delta Dental does not enter into the Dental Wellness Plan PAHP Contract, this Agreement shall be null and void *ab initio*.

3. Incorporated Documents.

(a) **"Incorporated Documents"** means all of the following documents and agreements, as the same may be amended or restated from time to time: (i) all documented rules and regulations of Delta Dental relating to the Dental Wellness Plan product, including, without limitation, the Delta Dental of Iowa Dental Wellness Plan Uniform Regulations (the **"Uniform Regulations"**); (ii) the Delta Dental of Iowa Dental Wellness Plan Office Manual (the **"Office Manual"**); (iii) any documented utilization, pre-treatment, pre-determination, post-treatment, office audit, focused review or other programs, and any Dental Wellness Plan incentive or bonus program, established and implemented by Delta Dental; (iv) the Dental Wellness Plan Fee Schedule (the **"Fee Schedule"**); and (v) the Dental Wellness Plan PAHP Contract.

(b) Delta Dental shall make all Incorporated Documents accessible to Participating Dentist by posting the same to Delta Dental of Iowa's Dental Wellness Plan's provider Internet site promptly after the Incorporated Documents are completed, amended or restated by, or are otherwise made available to, Delta Dental.

(c) Delta Dental may amend or restate this Agreement or the Incorporated Documents or may add or remove documents and agreements to or from the definition of Incorporated Documents from time to time without the consent of Participating Dentist. Any such amendment, restatement, addition or removal shall be effective immediately upon notice to Participating Dentist unless a later effective date is set forth in such notice. No such amendment, restatement, addition or removal shall retroactively apply to dental services provided prior to the effective date of such amendment, restatement, addition or removal, unless such retroactive application is required by law.

(d) In the event of a conflict between the terms of this Agreement and the terms of an Incorporated Document (other than the mandatory provisions of the Iowa Health and Wellness Plan Contract), the terms of this Agreement shall control. In the event of a conflict between the mandatory provisions of the Dental Wellness Plan PAHP Contract and the terms of this Agreement or any other Incorporated Document, the mandatory provisions of the Dental Wellness Plan PAHP Contract shall control.

4. Obligations of Participating Dentist; Indemnification**.** Participating Dentist agrees to abide by and comply with (a) all applicable federal and state laws, rules and regulations, and (b) the terms and conditions of all Incorporated Documents, including, without limitation, the credentialing requirements contained therein. Participating Dentist shall immediately notify Delta Dental in writing of any breach or non-compliance by Participating Dentist of this Section 4. Delta Dental shall not be responsible or liable in any manner whatsoever for any act or omission of Participating Dentist, including, without limitation, Participating Dentist's noncompliance with this Section 4 or Participating Dentist's negligent or wrongful acts. Participating Dentist shall defend, indemnify and hold Delta Dental, its affiliates, and their respective officers, directors, agents and employees harmless from and against any and all claims, demands, liabilities, losses, damages, actions, judgments, costs, expenses, fines and reasonable attorneys' fees incurred by any of them arising out of or relating to any breach of this Agreement by Participating Dentist, Participating Dentist's negligent acts, omissions or willful misconduct or any violation by Participating Dentist of any applicable federal or state law, rule or regulation.

5. Payment**.** Subject in all events to the terms and conditions of this Agreement and all Incorporated Documents, including, without limitation, Section 5 of the Uniform Regulations, Participating Dentist shall accept from Delta Dental as payment in full for Covered Services the lesser of: (i) the applicable amount set forth in the Fee Schedule or (ii) Participating Dentist's standard fees for such Covered Services. Participating Dentist shall not bill the Covered Enrollee for the balance, if any, between Participating Dentist's standard fees for such Covered Services and the applicable amount paid under the Fee Schedule.

6. Termination**.** Either party may terminate this Agreement, with or without cause, by giving the other party at least sixty (60) days prior notice. In addition, Delta Dental may terminate this Agreement for cause as provided in the Uniform Regulations. This Agreement will automatically terminate upon the death of Participating Dentist.

7. Notice**.**

(a) All notices, demands, requests, and other communications desired or required to be given hereunder, shall be in writing and shall be given by: (i) hand delivery to the applicable address for notices set forth below; (ii) delivery by overnight courier service to the applicable address for notices set forth below; or (iii) sending the same by United States mail, postage prepaid, certified mail, return receipt requested, addressed to the applicable address for notices set forth below. In addition to the foregoing, Delta Dental may provide notice to Participating Dentist of any amendment or restatement of this Agreement or of an Incorporated Document, or any addition or removal of an agreement or document to or from the definition of Incorporated Documents by e-mailing such notice to Participating

Dentist.

(b) All notices shall be deemed given and effective upon the earliest to occur of: (i) the hand delivery of such notice to the applicable address for notices set forth below; (ii) one business day after the deposit of such notice with an overnight courier service by the time deadline for next day delivery addressed to the applicable address for notices set forth below; or (iii) three business days after depositing the notice in the United States mail as set forth in (a)(iii) above addressed to the applicable address for notices set forth below. E-mail notices from Delta Dental to Participating Dentist permitted under Section 7(a) above shall be deemed given and effective on the date and at the time sent by Delta Dental, and no acknowledgement of receipt shall be required to make any such e-mail notice effective.

(c) Notices to Delta Dental shall be provided to Delta Dental of Iowa, 9000 Northpark Drive, Johnston, Iowa 50131, Attn: Professional Relations, or to such other address as may be updated from time to time by Delta Dental informing Participating Dentist of the same. Notices to Participating Dentist shall be provided to the address or e-mail address, as applicable set forth on the signature page to this Agreement, as the same may be updated by Participating Dentist from time to time by Participating Dentist providing notice to Delta Dental of the same. Participating Dentist shall ensure that Delta Dental has at all times an updated e-mail address for Participating Dentist.

8. Non-Exclusivity. Nothing herein shall preclude Participating Dentist from contracting with other insurance companies or carriers related to dental services. Nothing herein shall preclude Delta Dental from contracting with other dentists and providers to provide Covered Services to Covered Enrollees. Delta Dental may establish networks limited to certain dentists and provide financial and other incentive programs that may cause a Covered Enrollee to use the services of dentists or other providers other than Participating Dentist. Participating Dentist may not be eligible for such networks and programs, and such networks and programs may not be offered to all dentists.

9. General Provisions. Participating Dentist is an independent contractor of Delta Dental and none of the provisions of this Agreement are intended to create or to be construed as creating any employee-employer or agency relationship between them. Participating Dentist may not assign, delegate or subcontract Participating Dentist's rights, duties or obligations under this Agreement, in whole or in part, without the prior written consent of Delta Dental, which consent Delta Dental may withhold in its sole and unfettered discretion. Any assignment not in accordance with this Agreement shall be null and void. No failure or delay on the part of any party in exercising any right, power or remedy hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of any such right, power or remedy preclude any other or further

exercise thereof or the exercise of any other right, power or remedy. The remedies provided for herein are cumulative and are not exclusive of any remedies that may be available to any party at law or in equity or otherwise. Except as provided in Sections 3(c) and 7(a) of this Agreement, no amendment, modification, supplement, termination or waiver of or to any provision of this Agreement, nor consent to any departure therefrom, shall be effective unless the same shall be in writing and signed by or on behalf of the party to be charged with the enforcement thereof. Any amendment, modification or supplement of or to any provision of this Agreement, any waiver of any provision of this Agreement, and any consent to any departure from the terms of any provision of this Agreement, shall be effective only in the specific instance and for the specific purpose for which made or given. In the event any provision of this Agreement is held invalid, illegal or unenforceable, in whole or in part, the remaining provisions of this Agreement shall not be affected thereby and shall continue to be valid and enforceable. In the event any provision of this Agreement is held to be unenforceable as written, but enforceable if modified, then such provision shall be deemed to be amended to such extent as shall be necessary for such provision to be enforceable and it shall be enforced to that extent. This Agreement may be executed by the parties to this Agreement on any number of separate counterparts (including by facsimile or electronic transmission), and all of said counterparts taken together shall be deemed to constitute one and the same instrument. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective heirs, successors, legal representatives and permitted assigns. Nothing in this Agreement, express or implied, is intended to confer upon any party other than the parties hereto (and their respective heirs, successors, legal representatives and permitted assigns) any rights, remedies, liabilities or obligations under or by reason of this Agreement. This Agreement shall not be construed more strongly against either party regardless of who was more responsible for its preparation.

10. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Iowa, without regard to provisions thereof relating to conflicts of law.

11. Venue. Each of the parties hereby irrevocably submits to the exclusive jurisdiction of any United States or Iowa District Court sitting in Des Moines, Iowa in any action or proceeding arising out of or relating to this Agreement, and each party hereby irrevocably agrees that all claims in respect of such action or proceeding may be heard and determined in any such court. Each of the parties irrevocably waives any objection, including without limitation, any objection to the laying of venue or based on the grounds of forum non conveniens, which it may now or hereafter have to the bringing of any such action or proceedings in such respective jurisdictions. Each of the parties irrevocably consents to the service of any and all process in any such action or proceeding brought in any court in or of the State of Iowa by the delivery of copies of such process to each party, at its address specified for notices to be given hereunder.

[Signature page follows]

Participating Dentist may not bring any legal or equitable action on or with respect to any claim arising out of or relating to this Agreement more than two (2) years after the cause of action arose.

Delta Dental and Participating Dentist each hereby voluntarily, irrevocably and unconditionally waives all right to trial by jury in any action, proceeding or counterclaim arising out of or relating to this Agreement.

Accepted by: Delta Dental of Iowa on this _____ day of _____, _____. _____ Dental Director, Delta Dental of Iowa _____ President and CEO, Delta Dental of Iowa	Participating Dentist: Signature _____ (name of Participating Dentist) Print Name_____ Address_____ City/Zip_____ Email_____ Tax ID Number_____ Date_____

Form – DWP -01
Effective: 7/01/2017

Delta Dental of Iowa
Dental Wellness Plan
Uniform Regulations

1. **Incorporation by Reference.** These Delta Dental of Iowa Dental Wellness Plan Uniform Regulations (**"Uniform Regulations"**) are incorporated by reference into, and made a part of, the Delta Dental Participating Dentist Dental Wellness Plan Agreement (the **"Agreement"**) made between Delta Dental of Iowa (**"Delta Dental"**) and Participating Dentist.

2. **Terms Defined.**

(a) **"Board of Directors"** means the Board of Directors of Delta Dental.

(b) **"Dentally Necessary"** has the meaning set forth at Section 12 of these Uniform Regulations.

(c) Capitalized terms used but not otherwise defined herein shall have the meaning ascribed to such terms in the Agreement.

3. **Acceptance of Covered Enrollees.** Participating Dentist shall accept and provide Covered Services to Covered Enrollees upon the terms and conditions provided herein. If an individual was an existing patient of Participating Dentist under a different Delta Dental product prior to becoming, or when such individual became, a Covered Enrollee, Participating Dentist shall continue to provide dental services to such individual notwithstanding such individual's enrollment in the Dental Wellness Plan product.

4. **Prior Authorization.** The Office Manual will provide a listing of dental services that require prior authorization from Delta Dental. In the event a Participating Dentist does not obtain prior authorization for a dental service that requires prior authorization, no payment shall be made or required for such dental service.

5. **Payment.**

(a) Participating Dentist shall be paid according to the terms of the Agreement, including these Uniform Regulations, the Iowa Health and Wellness Plan Contract, the Fee Schedule and the Office Manual. In connection with the foregoing, Participating Dentist acknowledges and agrees that what is considered a Covered Service will be determined, in part, by (i) Delta Dental's interpretation of the Dental Wellness Plan Pre-Paid Ambulatory Health Plan (PAHP) Contract and (ii) Delta Dental's criteria for payment.

(b) Notwithstanding the foregoing or anything in the Agreement or any other Incorporated Document that is or may appear to be to the contrary, Participating Dentist understands that Delta Dental shall not be liable for and shall have no obligation to pay for any dental services whatsoever to the extent Delta Dental does not receive payment therefor from the Iowa Medicaid Enterprise.

(c) Participating Dentist shall not require prepayment from, or otherwise bill, Covered Enrollee for or with respect to any Covered Services. Without limiting the generality of the foregoing, Covered Enrollee shall under no circumstances whatsoever, including, without limitation, the insolvency of Delta Dental or the lack of adequate funding from the Iowa Medicaid Enterprise, be liable for money owed to Participating Dentist by Delta Dental and in no event shall Participating Dentist collect, or attempt to collect, from a Covered Enrollee any money owed to Participating Dentist by Delta Dental.

(d) Without limiting Participating Dentist's obligations under Section 12 of these Uniform Regulations, Participating Dentist shall inform Covered Enrollees of all available treatment options and associated financial responsibilities.

(e) Participating Dentist shall not charge greater fees for Covered Services provided to Covered Enrollee than Participating Dentist charges for Participating Dentist's other patients. All Covered Services shall be provided to Covered Enrollees with the same quality and accessibility in terms of timeliness, duration and scope as provided to Participating Dentist's other patients.

(f) Participating Dentist shall accept payment from Delta Dental by electronic funds transfer (direct deposit) to an account designated by Participating Dentist. Participating Dentist shall provide Delta Dental with all appropriate documents in order to set up such direct deposit.

6. Information And Records. Participating Dentist shall furnish information to Delta Dental accurately and on a timely basis, using applicable reporting forms or other means of transmittal supplied or approved by Delta Dental, and in accordance with instructions issued by Delta Dental. Participating Dentist shall prepare, retain and preserve in accordance with prudent record-keeping practices and procedures and otherwise as required by law, legible dental, financial and other records and data with respect to the Covered Services and Participating Dentist's compliance with the terms and conditions of the Agreement and applicable law, including dental records, claim forms and other evidence that sufficiently documents charges for all Covered Services. Participating Dentist shall make available to Delta Dental and any regulatory authority or other agency or body with oversight over Delta Dental or Participating Dentist upon request all such records. Participating Dentist shall obtain from Covered Enrollees any consents and authorizations necessary in order to provide such records and information to Delta Dental. Participating Dentist's obligations under this Section 6 shall apply during the term of the Agreement and for a period of not less than six (6) years from the date of termination of the Agreement (or such longer period of time as is required by law).

7. Claims Filing. Participating Dentist shall file, at no charge, cost or expense to Delta Dental or the Covered Enrollee, claims for all completed Covered Services

furnished to Covered Enrollees. Claims shall be submitted electronically and in accordance with the billing instructions of Delta Dental as communicated to Participating Dentist from time to time.

Claim forms must be signed or submitted by the Participating Dentist. A Participating Dentist may not sign or submit a claim form on behalf of any other dentist, including, without limitation, any non-participating dentist.

Claims submitted to Delta Dental more than ninety (90) days after the date the dental services were rendered will be disallowed by Delta Dental absent a showing of exceptional circumstances by Participating Dentist. Exceptional circumstances will be determined by Delta Dental in its sole discretion on a case-by-case basis, but exceptional circumstances may include, without limitation, claims that include coordination of benefits or require information from a third-party outside of the Participating Dentist's control. In all events, claims must be completed and finalized within 365 days after the date the dental services were rendered or they will be disallowed. Without limiting the terms of Section 5 of these Uniform Regulations, a disallowed claim may not be billed to the Covered Enrollee.

8. In-Office Records Verification. Delta Dental and its representatives may make periodic examinations of a Participating Dentist's office and records (including, without limitation, the records required to be maintained under Section 6 of these Uniform Regulations) during regular office hours to determine Participating Dentist's compliance with the Agreement. Without limiting the generality of the foregoing, Delta Dental may request, and Participating Dentist shall provide at no cost to Delta Dental, de-identified data regarding fees charged to other patients. Participating Dentist understands and agrees that governmental agencies with regulatory authority over the Dental Wellness Plan product shall also have access to Participating Dentist's office and records as required or permitted under applicable law.

9. Recoupment. In the event Delta Dental makes payments to a Participating Dentist and the payments are later determined by Delta Dental to have been made in error for any reason, including, without limitation, because the payments were for dental services that were not Covered Services because they were not Dentally Necessary, or because of Participating Dentist's error, Delta Dental's error, overpayment by Delta Dental or Medicaid, or a patient's ineligibility for coverage, Delta Dental may deduct from future payments due Participating Dentist amounts equal to the amount of the incorrect or unearned payments. Nothing in this Section 9 shall be deemed to be a limitation on Delta Dental's or any regulatory agency's ability to recover from Participating Dentist any amounts recoverable by Delta Dental or the regulatory agency under applicable law governing the Dental Wellness Plan product.

10. Coordination of Benefits. Benefits shall be coordinated with any other coverage the Covered Enrollee may have available to pay Covered Services. If a Covered Enrollee

is enrolled with other health or dental benefit coverage, the other benefit plan shall be the primary payor and the Dental Wellness Plan product shall be the payor of last resort. Participating Dentist shall cooperate, to the extent permitted by law, with Delta Dental's coordination of benefits and subrogation efforts, providing to Delta Dental such information as Participating Dentist may obtain regarding other payors. Participating Dentist shall ask prior to the performance of a Covered Service for a Covered Enrollee whether Covered Enrollee has private insurance.

11. Confidentiality; Product Data. All dental records containing specific patient information disclosed to Delta Dental shall be considered confidential to the extent required by applicable law. Upon request of the Covered Enrollee or the Covered Enrollee's legal representative, Participating Dentist shall transfer or copy such Covered Enrollee's treatment records. Participating Dentist may charge a nominal fee for duplication of the records, but may not refuse to transfer records for nonpayment of any fees, in accordance with applicable Iowa Dental Board regulations.

To the extent Delta Dental develops or collects information related to its products, including, without limitation, any claims, cost, utilization, outcomes, quality and financial performance information (collectively, **"Product Data"**), Delta Dental shall be the sole and exclusive owner of all such Product Data, including, without limitation, any Product Data that relates to dental services provided by Participating Dentist to a Covered Enrollee (collectively, such Product Data is referred to as **"Dentist Specific Product Data"**). Participating Dentist shall keep all Product Data confidential and shall only use Product Data for the purpose of carrying out Participating Dentist's obligations hereunder. Upon termination of this Agreement, Participating Dentist shall return to Delta Dental all Product Data that is not Dentist Specific Product Data. To the extent permitted by law, Delta Dental reserves the right to use and disclose, in its discretion, Product Data and information derived from Product Data. Such information may explicitly or implicitly identify Participating Dentist and include, but not be limited to, actual or projected payment levels made to Participating Dentist.

12. Dentally Necessary. In addition to the further terms and conditions of the Agreement, including the Incorporated Documents, Participating Dentist shall furnish and will receive payment only for dental services that are Dentally Necessary. Delta Dental shall not be responsible to pay for dental services that are not Dentally Necessary. Prior to providing a Covered Enrollee with dental services that are not Dentally Necessary, a Participating Dentist shall inform the Covered Enrollee of Delta Dental's payment policies and obtain a written acknowledgement from the Covered Enrollee that he/she has been informed that the dental services may not be paid by a third party. In the event a payment is made to Participating Dentist by Delta Dental for dental services that are later determined not to be Dentally Necessary, Delta Dental (or the applicable regulatory agency) may recoup payment pursuant to Section 9 above.

A procedure, service or supply shall be considered **"Dentally Necessary"** if and only if Delta Dental determines that each of the following statements is true with respect to such procedure, service or supply:

- The diagnosis is proper;
- The treatment is necessary to preserve or restore the basic form and the function of the teeth and the health of the gums, bone and other tissues, which support the teeth;
- It is the most appropriate procedure, service or supply for the Covered Enrollee's individual circumstances; and
- It is consistent with and meets professionally recognized standards of dental care, and complies with criteria adopted by Delta Dental.

Participating Dentist acknowledges that payments for alternate dental services in lieu of payments for services actually submitted as a claim may be made to Participating Dentist if such alternate dental services are equally effective for the treatment or maintenance of the teeth and their supporting structures.

Notwithstanding the foregoing and in all events Participating Dentist shall exercise his or her independent professional judgment in providing dental services. Nothing herein shall be construed to (a) interfere with or otherwise affect the rendering of dental services by Participating Dentist in accordance with Participating Dentist's independent professional judgment, or (b) prohibit or otherwise restrict Participating Dentist, acting within the lawful scope of his or her profession, from discussing with a Covered Enrollee the Covered Enrollee's health status and dental care or treatment options.

13. **Credentialing; Quality Assurance.** Participating Dentist shall furnish Delta Dental all credentialing information requested by Delta Dental, including professional application and profile information, to assist Delta Dental in its evaluation of Participating Dentist's dental practice. In addition to such other information as Delta Dental may request from time to time, Participating Dentist shall provide the following credentialing documents and information: (i) an accurate and complete Professional Application and Credentialing Form at least every four (4) years; (ii) an active state-issued dental license; (iii) evidence of malpractice liability coverage in amounts required by Delta Dental; (iv) disclosure of any termination, suspension, limitation, surrender or restriction on Participating Dentist's license, accreditation, certification, permit or other governmental authorization; (v) disclosure of any licensing board actions, malpractice claims and other adverse personal matters (including any criminal charges); and (vi) compliance with Occupational Safety and Health Administration requirements and Centers for Disease Control recommended infection control guidelines. Participating Dentist shall notify Delta Dental immediately of any changes to this credentialing information or the occurrence of any matter requiring disclosure. All of Participating Dentist's rights and Delta Dental's obligations under the Agreement, including these Uniform Regulations, are conditioned upon Participating Dentist's continued

maintenance of such credentialing requirements including, but not limited to, licenses and professional liability insurance, with no restrictions placed thereon and non-exclusion status on the HHS-OIG report, and the non-occurrence of any event requiring disclosure. So long as Participating Dentist has been and is currently credentialed with Delta Dental his or her name will be included in all directories for the Dental Wellness Plan product.

14. Discrimination. Participating Dentist shall not differentiate or discriminate in the treatment of Covered Enrollees or in the quality of service because of race, sex, color, creed, national origin, age, religion, physical or mental disability, political belief, sexual orientation or health status. In addition, Participating Dentist may not discriminate based on payment policies of Delta Dental or against Covered Enrollees who are participants in a publicly financed program, including the Iowa Health and Wellness Plan.

15. Compliance with Laws; ADA and IDB Principles and Ethics. Participating Dentist shall conduct Participating Dentist's practice in accordance with the principles and ethics of the American Dental Association and the Iowa Dental Board. Participating Dentist shall comply with all applicable state and federal laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder.

16. Communications. Participating Dentist shall not make, publish, disseminate, or circulate, directly or indirectly, or aid, abet, or encourage the making, publishing, disseminating or circulating of any oral or written statement or pamphlet, circular, article, or literature that is false or maliciously critical of Delta Dental and that may have an adverse affect on Delta Dental. Participating Dentist shall not misrepresent the provisions, terms, or requirements of policies approved by and plans administered by Delta Dental. Nothing herein shall prohibit a Participating Dentist from reporting to state or federal authorities any act or practice by Delta Dental that jeopardizes patient health or welfare.

17. Safety and Hygiene. Participating Dentist shall comply with and be responsible for any and all applicable legal requirements related to dental practice safety and hygiene. Infection control is an integral part of all dental procedures. Delta Dental's payment pursuant to the Agreement includes reimbursement to the Participating Dentist for infection control costs and, therefore, infection control may not be billed separately from other dental procedures to either the Covered Enrollee or Delta Dental.

18. Changes in Participating Status. Delta Dental may notify Covered Enrollees when the Agreement is terminated. Participating Dentist must promptly notify Covered Enrollees who have been patients of Participating Dentist in the event the Agreement is terminated prior to additional services being rendered. A copy of any form of written communication from Delta Dental to a Covered Enrollee regarding a termination of the

Agreement will be provided to Participating Dentist. Similarly, a copy of any written communication from Participating Dentist to a Covered Enrollee regarding a termination of the Agreement shall be provided to Delta Dental.

19. Termination of Participating Dentist's Agreement For Cause by Delta Dental. Without limiting Delta Dental's right to terminate the Agreement without cause as provided in the Agreement, Delta Dental may terminate the Agreement if Participating Dentist breaches or violates any of the provisions of the Agreement, including any Incorporated Document, Participating Dentist's license to engage in the practice of dentistry is suspended or terminated in any jurisdiction, or Participating Dentist's conduct is determined by Delta Dental to be unprofessional and/or to be detrimental to Delta Dental or Covered Enrollees.

Any such termination shall be effective on the date designated by Delta Dental in a notice of termination (the **"Notice of Termination"**) provided to Participating Dentist (which may be immediate). The Notice of Termination will state the reasons for such termination and that the Participating Dentist has a right to request a hearing on the termination as provided in Section 20 of these Uniform Regulations.

20. Termination of Participating Dentist For Cause – Appeal. Process.

(a) **Provider Appeals Committee.** The Chair of the Board of Directors (the **"Chair"**) with the approval of the Board of Directors shall appoint a Provider Appeals Committee to hear appeals from Participating Dentists whose Agreements with Delta Dental have been terminated for cause. The Provider Appeals Committee shall consist of not more than twelve (12) persons, none of whom may be current members of the Board of Directors. When an appeal is filed by a Participating Dentist who has been terminated for cause, such appeal shall be determined as set forth hereafter.

(b) **Request For Appeal.** Any Participating Dentist who has been served with a Notice of Termination that Delta Dental has terminated or intends to terminate the Participating Dentist's Agreement for cause may appeal the Notice of Termination. A Participating Dentist who has been served with a Notice of Termination for cause shall begin the appeal process by sending a written notice of appeal and request for a hearing (**"Notice of Appeal"**) by certified mail, return receipt requested to the Chief Executive Officer at Delta Dental's address for notices. A Notice of Appeal must be received by Delta Dental within thirty (30) days after the date of the Notice of Termination. The Notice of Appeal shall state the grounds for appeal and the reasons the Participating Dentist believes Delta Dental should not terminate the Agreement. Failure to deliver the Notice of Appeal within the thirty (30)-day period noted above shall constitute a waiver of the Participating Dentist's right to the hearing and subsequent review and appeal.

(c) **Appeal May Stay Termination.** Upon timely receipt of a written Notice of Appeal, the Chief Executive Officer may, but is not required to, stay the termination of the Agreement until the appeal process is completed.

(d) **Provider Appeals Committee Panel.** The Chief Executive Officer shall appoint a panel (the **"Panel"**) comprised of no fewer than three (3) members of the Provider Appeals Committee to hear and decide an appeal filed by a Participating Dentist. The Panel shall be comprised of at least one (1) person who is a Participating Dentist. A Participating Dentist appointed to the Panel shall not be in direct economic competition with the Participating Dentist who has filed an appeal. The Chief Executive Officer shall select one member of the Panel to serve as chair of the Panel (the **"Panel Chair"**) who shall preside over the hearing and the deliberations incident to said appeal. The Panel Chair shall have a vote in the proceedings.

(e) **Setting a Hearing Date.** Within thirty (30) days after receiving the Notice of Appeal, the Panel Chair shall set the date of the hearing and so notify the Participating Dentist. The date of the hearing shall not be more than thirty (30) days after such notice is received by the Participating Dentist. The Panel shall conduct an oral hearing on the Notice of Appeal at the offices of Delta Dental.

(f) **Conduct of Hearing.** A hearing conducted by the Panel shall be presided over by the Panel Chair. The hearing will be reported by a Certified Shorthand Reporter (CSR) authorized to administer oaths within the State of Iowa. The CSR shall administer the oath to all witnesses. At such hearing, Delta Dental shall state its grounds for terminating the Participating Dentist's Agreement. The Participating Dentist shall then be allowed to state the reasons why the Agreement should not be terminated. The Participating Dentist and Delta Dental may be represented by counsel and each party may call witnesses. Each party shall be responsible for any costs associated with its presentation. The personal presence of the Participating Dentist for whom the hearing has been scheduled shall be required. A Participating Dentist who fails without good cause to appear and proceed at such hearing shall be deemed to have waived the right to appeal the termination and to have accepted the termination. Postponement of hearings beyond the time set forth in these Uniform Regulations shall be made only with the approval of the Panel. The granting of such postponements shall only be for good cause shown, and shall be in the sole discretion of the Panel. If either party is to have counsel present, that party shall inform the other party of the name and address of such counsel no less than ten (10) days prior to the hearing. Nothing contained herein shall preclude Delta Dental and the Participating Dentist from resolving the matter prior to the time scheduled for the hearing.

(g) **Decisions by Provider Appeals Committee Panel.** At the conclusion of the hearing, the Panel shall deliberate in executive session. Decisions by the Panel

shall be reached by a majority vote of the members present at the hearing. The decision shall be in writing and a copy shall be mailed to the Participating Dentist within ten (10) days after the oral hearing.

(h) **Review of Appeal of Provider Appeals Committee Panel Decisions.** Decisions made by the Panel may be appealed to the Board of Directors for review (**"Review of Appeal"**) by sending a written Notice of Appeal by certified mail, return receipt requested to the Chair of the Board of Directors at Delta Dental's corporate offices within thirty (30) days after the date of the Panel's decision. No new or additional matters not raised during the original hearing and not otherwise reflected in the record shall be introduced at the Board of Directors Review of Appeal unless the Board of Directors shall, in its sole discretion, allow such new matters to be offered. Participating Dentist shall not be entitled to more than one hearing and one Board of Directors Review of Appeal of a termination. Failure of the Panel or Board of Directors to comply with a time limit specified herein shall not invalidate their actions. Failure to appeal the Panel's decision within the time and in the manner herein provided shall be a waiver of the Participating Dentist's right to such an appeal.

(i) **Board of Directors Review of Appeal.** Within thirty (30) days after receiving the Notice of Appeal, the Board of Directors shall review the Notice of Appeal and the proceedings before the Panel, and shall either schedule an oral hearing or decide the matter based on the record of proceedings before the Panel. The Participating Dentist may submit a written statement on Participating Dentist's behalf by sending it to the Board of Directors through Delta Dental's Chief Executive Officer at least five (5) days prior to the scheduled date for the review of the appeal.

(j) **Conduct of Hearing.** If the Board of Directors elects to hold a hearing, the hearing shall be conducted in the following manner. The hearing shall be presided over by the Chair, and shall be held at the offices of Delta Dental. Delta Dental shall state its grounds for terminating the Agreement. The Participating Dentist shall then be allowed to state the reasons why the Agreement should not be terminated. The Participating Dentist's presentation must comply with Section 20(h). The Participating Dentist and Delta Dental may be represented by counsel and each party may call witnesses. Each party shall be responsible for any costs associated with its presentation. The personal presence of the Participating Dentist for whom the hearing has been scheduled shall be required. A Participating Dentist who fails without good cause to appear and proceed at such hearing shall be deemed to have waived the Participating Dentist's rights to appeal the termination to the Board of Directors and to have accepted the termination.

(k) **Decisions by Board of Directors.** Decisions by the Board of Directors shall be reached by a majority vote of the members present at the hearing and shall be

conclusive, final and non-appealable if made in good faith. The Board of Directors shall notify the Participating Dentist within ten (10) days of its decision on the appeal.

(l) **Quorum of the Board of Directors**. A quorum of the Board of Directors, as provided in the Bylaws of Delta Dental, shall be required for the Board of Directors to conduct the hearing.

(m) **Conference Telephone Meetings.** Attendance at the hearing may be by means of conference telephone or similar communications equipment through which all persons participating in the hearing can hear each other. Participation in the hearing pursuant to this provision shall constitute presence in person at such hearing.

(n) **Continuance**. The Provider Appeals Committee Panel and the Board of Directors may grant a continuance on any appeal.

(o) **Legal Action. In consideration of Delta Dental's acceptance of a Participating Dentist's Agreement, the Participating Dentist waives any and all legal action that the Participating Dentist may have against the Provider Appeals Committee, the Panel, the Board of Directors, and Delta Dental, its officers, agents and employees, arising out of or in the conduct of appeals pursuant to this Section 20.**

DELTA DENTAL

DELTA DENTAL OF IOWA DENTAL WELLNESS PLAN
PROFESSIONAL APPLICATION & CREDENTIALING FORM

Delta Dental of Iowa is dedicated to improving the health and smiles of the people we serve. Part of that commitment is meeting the credentialing standards set by Delta Dental Plans Association, State and Federal Government Regulations, and Group Purchasers of dental benefits. To meet this requirement, the following information must be completed and signed by the dentist.

PLEASE NOTE THE LIST OF REQUIRED ITEMS ON PAGE 3 THAT MUST BE RETURNED WITH THIS FORM

I. Licensure Information		
Requested effective date: **(Participation effective date will be no more than 30 days prior to receipt of complete application.)**		
Dentist's Full Name:		
State License #:	DEA #: CDS #: **(If not yet available, write pending in this space. If not applicable, write N/A in this space.)**	
Individual NPI (type 1):		
Social Security #:	Date of Birth:	Gender: M F
Please provide an email for direct clinical/professional communications with dentist. **(This will not be published on website.)**		
Dental School Name/City/State/Country if out of USA:		
Date Graduated:	Degree Conferred:	
Specialty:	Are you Board certified? Yes_____ No_____	

List current hospital privileges and other facility affiliations (i.e. nursing homes, surgery centers) below:

Facility Name	City and State	Effective Date	Expiration Date

List active, pending, or inactive licenses to practice dentistry in any state other than the one listed above.

State:	State:	State:	State:
License #:	License #:	License #:	License #:

List any other names you have used (i.e. maiden name, nickname).

II. Office Information (Iowa Locations Only)

Complete information below for up to two offices. Duplicate this page and complete for additional offices.

Office Information for Location One:					
Centers for Disease Control guidelines for infection control are followed in office.				Y	N
Office is OSHA compliant.				Y	N
Business Name:		Tax ID Number:	Organizational NPI (Type 2):		
Office Address: **(Full address including suffix [i.e. Ave., Blvd.], Suite #, etc. for GEO mapping.)**			County:		
PO Box or Payment Address (if different than physical address):					
Telephone:	General Office Email:				
Fax:	Office Manager Email:				
Office Website:					
Office Hours:	Before 8 AM? Y N After 5 PM? Y N		Emergency Office Hours? Y N Weekends? Y N		
List languages spoken other than English: Office uses a translation service (e.g. Language Line). Y _____ N _____					
Accepting new patients?	Y	N	Wheelchair accessible?	Y	N
Free parking?	Y	N	Public transit access (e.g. bus)?	Y	N
Electronic claim filing?	Y	N	Internet to access DDIA's website?	Y	N
Treat disabled adults?	Y	N	Treat disabled children?	Y	N

Office Information for Location Two:

Centers for Disease Control guidelines for infection control are followed in office.				Y	N
Office is OSHA compliant.				Y	N
Business Name:		Tax ID Number:	Organizational NPI (Type 2):		
Office Address: **(Full address including suffix [i.e. Ave., Blvd.], Suite #, etc. for GEO mapping.)**			County:		
PO Box or Payment Address (if different than physical address):					
Telephone:	General Office Email:				
Fax:	Office Manager Email:				
Office Website:					
Office Hours:	Before 8 AM? Y N After 5 PM? Y N		Emergency Office Hours? Y N Weekends? Y N		
List languages spoken other than English: Office uses a translation service (e.g. Language Line). Y _____ N _____					
Accepting new patients?	Y	N	Wheelchair accessible?	Y	N
Free parking?	Y	N	Public transit access (e.g. bus)?	Y	N
Electronic claim filing?	Y	N	Internet to access DDIA's website?	Y	N
Treat disabled adults?	Y	N	Treat disabled children?	Y	N

III. Individual Dentist Information		
Are you currently a Medicaid provider in your State?	Y	N
Are you currently a Medicaid Ordering/Referring provider in your State?	Y	N

An explanation is required if you answer "yes" to any of the following questions. For required explanations, use the back of this form or a separate sheet of paper and include the question number, dates, circumstances, and dispositions.

1. Are you **ineligible** for DEA or CDS (State Controlled Substances) registrations or has your DEA or CDS certification been denied, revoked, limited, suspended, put on probation, or voluntarily relinquished? **If yes**, explanation required.	Y	N
2. Have you ever been disciplined by a state board of dental examiners? **If yes**, explanation required.	Y	N
3. Have you ever been subject to any litigation or had any malpractice claims or suits pertaining to your dental practice filed against you? **If yes**, explanation required.	Y	N
4. Has information pertaining to you been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? **If yes**, explanation required.	Y	N
5. Has your professional license in any state ever been denied, revoked, limited, suspended, put on probation, or voluntarily relinquished? **If yes**, explanation required.	Y	N
6. Have you ever been convicted of a felony or are any felony charges now pending against you for any reason? **If yes**, explanation required.	Y	N
7. Have you ever been excluded by the federal Office of the Inspector General or denied, expelled, or suspended from participating in a state or federal health care program including Medicare or Medicaid? **If yes**, explanation required.	Y	N
8. Have you ever been subject to peer review action? **If yes**, explanation required.	Y	N
9. Have you ever had, or do you presently have, a chemical dependency, substance abuse condition, mental health condition, or physical condition (such as infectious disease) that would interfere with your ability to practice dentistry or could in any way endanger your patients? **If yes**, explanation required.	Y	N

Please enclose these required documents with your credentialing form:

- **Required explanations to questions.**
- **A complete professional work history or Curriculum Vitae. Explain any gaps in work history.**
- **A copy of the declarations page of your professional liability certificate that contains the carrier name, covered dentist's name, policy number, limits, and coverage period.**
- **A copy of certification of specialty training or education, if applicable.**
- **A completed W-9 for each office location.**

I understand that it is my responsibility to provide complete credentialing (and re-credentialing) information to Delta Dental of Iowa (DDIA). I certify that the information provided by me is true to the best of my knowledge. I agree to notify DDIA of any changes in this information (including professional liability information) within 30 calendar days. I understand that the information I have provided will be reviewed by DDIA and that other information may be obtained in accordance with the DDIA credentialing program. I further understand that my willingness to provide complete and truthful information will help ensure the continuation of my participating status with Delta Dental.

Dentist's Signature: _____ **Date:** _____

Mail completed form and attachments to: Delta Dental of Iowa, 9000 Northpark Dr., Johnston, IA 50131
Or fax to: (515) 261-5608
Call Professional Relations with Questions: (800) 544-0718

Ownership & Control Disclosure Form

Entity Name:	**Tax Identification Number:**
Individual NPI: **(If Applicable)**	**Organizational NPI:** **(If Applicable)**

Only one form is required per Tax Identification Number. Completion and submission of this form to Delta Dental of Iowa is a condition of participation in any of the programs established by Titles V, XVIII, XIX, and XX. This includes ***hawk-i***, the Dental Wellness Plan, and any other government programs. It is the disclosing entity's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Control Disclosure form.

Pursuant to Code of Federal Regulations Title 42 CFR sec. 455.104 and 455.105, providers must disclose the following information if they have ownership or control interests in the business entity for the tax identification number listed above.

1. The name and address of each person with an ownership or control interest in the business entity or any subcontractor in which this business entity has direct or indirect ownership of 5 percent or more;
2. Whether any of the persons with ownership and control interest is related to another person with ownership and control interest (as spouse, parent, child, or sibling).
3. The name of any other business entity in which a person with ownership or control interest in this business entity also has an ownership or control interest.
4. The ownership of any subcontractor with whom the provider with ownership and control interest has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.
5. Any significant business transactions between the provider with ownership and control interest and any wholly owned supplier, or between the provider with ownership and control interest and any subcontractor, during the 5-year period ending on the date of the request.

Pursuant to 42 CFR sec. 455.106, providers with ownership and control interest must disclose the identity of any person who:

1. Has ownership or control interest in the provider, or is an agent or managing employee of the provider named above, and
2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of these programs.

Ownership

List any individual or business entity that has ownership interest in this organization. The date of birth and social security number of individuals and tax identification number of business entities are required. For purposes of this listing, the ownership interest can be direct, indirect, or a combination of direct and indirect. A direct ownership interest would include possession of equity in the capital, the stock, or the profits of your organization. An indirect ownership interest would include an ownership interest in an entity that has an ownership interest in your organization. Indirect ownership includes an ownership interest in any entity that has an indirect ownership interest in your organization. For business entities listed below that have an ownership interest in your organization, include separate line-item entries for the corporate entity's primary business address, every business location, and all P.O. Boxes used by the corporation.

Name or Business Entity	**Date of Birth**	**Social Security Number/Tax Identification**

For business entities listed above that have an ownership interest in your organization, include separate line-item entries for the corporate entity's primary business address, every business location and all P.O. Boxes used by the corporation.

Name or Business Entity Name	**Address**

Please copy this page if additional space is needed

Ownership of Other Providers	☐ Not Applicable - Skip to next section Controlling Interests

For each individual or business entity you disclosed on page two as having an ownership interest in your organization, list the name(s) of other ownership interests they may have (for example, ownership in a dental laboratory). When disclosing the ownership interests of your owners, you are only required to list the names of fiscal agents or other Medicaid providers (excluding individual practitioners or groups of practitioners).

Name or Business Entity

Please copy this page if additional space is needed

Controlling Interests	☐ Not Applicable - Skip to next section Individual Relationships

If you contract or subcontract with any other individual or entity in which you have an ownership interest of 5 percent or more, list below.

Subcontractor means an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients. Subcontractor also means an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

For purposes of this listing, the ownership interest can be direct, indirect, or a combination of direct and indirect. A direct ownership interest would include possession of equity in the capital, the stock, or the profits of your organization. An indirect ownership interest would include an ownership interest in an entity that has an ownership interest in your organization. Indirect ownership includes an ownership interest in any entity that has an indirect ownership interest in your provider entity.

Type: **Person/ Organization**	**Tax ID/SSN**	**Organization/Person Name**	**Date of Birth**

Please copy this page if additional space is needed

Individual Relationships ☐ Not Applicable - Skip to next section Managing Employees

List each person with an ownership or control interest in the disclosing entity and any subcontractor in which the disclosing entity has 5 percent or more ownership or control interest that have any relationship by blood, kinship, or marriage. Note that the individuals may have multiple relationships, such as:

- The provider is John S.
- Owner 1 of provider -- Sally S., John's wife.
- Owner 2 of provider -- Bill S., John's child and step-son of Sally
- Owner 3 of provider – Jane Doe, former wife of John S., and mother of Bill S.

SSN	Person Name	Relationship	Date of Birth

Please copy this page if additional space is needed

Managing Employees	☐ Not Applicable - Skip to next section Final Adverse Actions

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information regarding all managing employees:

SSN	Person Name	Title	Date of Birth

Please copy this page if additional space is needed

Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre- trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Adverse Actions

List below all individuals and business entities that are disclosed on any of the previous pages and:

1. If the person or business entity has not had an adverse action put an “N” in the “Y or N” box after the name.
2. If the organization or person has had an adverse action, put a “Y” in the “Y or N" box and report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Organization or Person Name	Y or N	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed

Adverse Actions

Patient Protection and Affordable Care Act

Does the provider have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider? ☐ Yes ☐ No

The term "affiliation" includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

Do any of the organizations or persons listed on page 8 have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including but not limited to the federal and Iowa governments?

☐ Yes ☐ No ☐ Not Sure If **Yes**, enter the name in the chart below

Name

Are any of the organizations or persons listed on page 8 currently subject or have they ever been subject to a payment suspension under a federally-funded health care program.

☐ Yes ☐ No ☐ Not Sure If **Yes**, enter the name in the chart below

Name

Please copy this page if additional space is needed

Adverse Actions

Have any of the organizations or persons listed on page 8 had billing privileges denied or revoked.

☐ Yes ☐ No ☐ Not Sure If **Yes**, enter the name in the chart below

Name

Have any of the organizations or persons listed on page 8 been excluded from participation under Medicaid, Medicare, or any other federally-funded health care program.

☐ Yes ☐ No ☐ Not Sure If **Yes**, enter the name in the chart below

Name

Do any of the organizations or persons listed on page 8 share a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt.

☐ Yes ☐ No ☐ Not Sure If **Yes**, enter the name in the chart below

Name

Please copy this page if additional space is needed

THE PROVIDER CERTIFIES THAT THE INFORMATION SUBMITTED ON THIS FORM IS, TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE FORM BEFORE SIGNING. THE PROVIDER AGREES TO CONTACT DELTA DENTAL OF IOWA WITHIN 30 CALENDAR DAYS OF ANY CHANGES IN THIS INFORMATION. THE PROVIDER ALSO UNDERSTANDS THAT PAYMENT OF CLAIMS WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW.

Printed Name of Legal Entity Signatory	
Signature of Authorized Signatory	Date

January 2016

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

Request for Taxpayer Identification Number and Certification

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

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

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

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

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

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

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

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

☐ Other (see instructions) ▶

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

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

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

DELTA DENTAL®

Delta Dental - Dental Wellness Plan

Direct Deposit / Electronic Funds Transfer (EFT)

Authorization Agreement – Instructions and Enrollment Form

Special Notes	• If you currently receive payments through Direct Deposit for any other Delta Dental of Iowa business, you do not need to complete and return this form. • Please complete and return this form if you do not receive payments by Direct Deposit today and will be receiving payments per this method for the Dental Wellness Plan network.
Where to Submit Completed Enrollment Form	Professional Relations Delta Dental of Iowa P.O. Box 9000 Johnston, IA 50131-9000 Fax: (515) 261-5608 Email: provrelations@deltadentalia.com
General Instructions	If you have multiple offices and would like Direct Deposit for each location, you must complete a form for each office location. Accuracy of all information is essential. If you have any questions, please contact Delta Dental's Professional Relations Team.
Delta Dental of Iowa Contact Information	Professional Relations Delta Dental of Iowa P.O. Box 9000 Johnston, IA 50131-9000 Phone: (888) 472-1205 Fax: (515) 261-5608 Email: provrelations@deltadentalia.com
Enrollment Confirmation	Once enrollment processes are complete, Delta Dental of Iowa will notify the provider via email or fax to confirm the Direct Deposit/EFT start date.
Late or Missing Direct Deposit/EFT	If the expected Direct Deposit/EFT appears to be late or missing, please contact Delta Dental of Iowa's Professional Relations Team at (888) 472-1205 or provrelations@deltadentalia.com.

DELTA DENTAL®

Dental Wellness Plan (DWP)
Direct Deposit / Electronic Funds Transfer (EFT) Enrollment Form

PROVIDER INFORMATION

Provider / Business Name

_____

Provider Address

_____ _____ _____ _____

(Street) (City) (State) (ZIP Code)

PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers

_____

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

_____ _____

National Provider Identifier (Individual Provider - NPI 1) National Provider Identifier (Organizational - NPI 2)

PROVIDER CONTACT INFORMATION

Provider Contact Name:

_____

_____ _____

Telephone Number Email Address

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name: _____

Financial Institution Telephone Number: _____

Financial Institution Routing Number: _____

Type of Account at Financial Institution: ❑ **Checking** ❑ **Savings**

Provider's Account Number with Financial Institution: _____

Account Number Linkage to Provider Identifier: _____

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

DELTA DENTAL®

SUBMISSION INFORMATION

Reason for Submission

(check one) ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Include with Enrollment Submission

(check one) ☐ Voided Check
☐ Bank Letter (A letter on bank letterhead that formally certifies the account owners routing and account numbers)

Authorized Signature (The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment)
This authority is to remain in full force and effective until Delta Dental of Iowa receives written notification from me/us of its termination in such time and manner as to afford Delta Dental of Iowa - Dental Wellness Plan reasonable opportunity to act on it. In addition, I (we) certify to the best of my (our) knowledge that the banking information given is not that of a foreign banking institution (located outside of the United States).*

Please sign, date and return completed form, along with voided check or bank letter to: Professional Relations, Delta Dental of Iowa, P.O. Box 9000, Johnston, IA 50131-9000 or Fax to 515-261-5608

_____
Written Signature of Person Submitting Enrollment and Title

_____
Printed Name of Person Submitting Enrollment

Submission Date: _____

Requested Direct Deposit Start/Change/Cancel Date: _____

*If you banking institution is a foreign bank, please contact Delta Dental of Iowa at (888) 472-1205 for further instructions.

EXPLANATION OF PAYMENT (EOP) DELIVERY OPTIONS

Select Delivery Option (choose one):

☐ E-mail notification with delivery of Explanation of Payment to Dental Wellness Plan website (www.DWPIowa.com)

_____
E-mail to receive direct deposit notification

☐ Paper Explanation of Payment sent via U.S. Postal Service

Delta Dental of Iowa Administrative Use Only:

_____ _____ _____
Date Delta Dental Representative Initials Payee Number