DELTA DENTAL®

DELTA DENTAL OF IOWA
PROFESSIONAL APPLICATION & CREDENTIALING FORM

Delta Dental of Iowa (DDIA) 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 of participation with DDIA, please complete this credentialing form and return with all required documents by email, mail, or fax to:

Email: credentialing@deltadentalia.com
Mail: Delta Dental of Iowa, 9000 Northpark Dr., Johnston, IA 50131, ATTN: Provider Relations
Fax: (515) 261-5608

Questions can be sent to credentialing@deltadentalia.com

Use the checklist below to ensure that you have included all necessary information before submitting to Delta Dental.

- ☐ **Complete and submit** all required and applicable fields of the credentialing form, with signature, including:
  - Explanation of any gaps in work history
  - Please provide an explanation in the space provided to any YES responses to the QUALITY FOCUSED QUESTIONS
- ☐ A copy of current professional liability insurance information that includes carrier name, covered dentist's name, policy number, limits (per occurrence and aggregate), and coverage period. Each dentist shall maintain minimal malpractice policy limits of $1,000,000 per claim and $3,000,000 aggregate.
- ☐ A copy of current Drug Enforcement Administration (DEA) registration, if applicable
- ☐ A copy of current Iowa Controlled Substance Act (CSA) registration, if applicable
- ☐ A copy of specialty certification, if applicable
- ☐ Sign and date applicable provider agreements
- ☐ For a new business, a completed W-9 for each office location
- ☐ For a new business, complete an Ownership & Control Disclosure Form. Make sure each page is completed. Signature page must be signed by owner or managing employee.

DELTA DENTAL®

Confidentiality Statement

Delta Dental of Iowa maintains all credentialing and re-credentialing information in a confidential manner and strictly enforces provisions designed to safeguard information and ensure confidentiality.

Practitioners Right to Review

As an applicant applying for and credentialing within the Delta Dental of Iowa (DDIA) network, you are entitled to specific rights. Our established processes are in place to facilitate your access to these rights.

Your rights include:

- The right to review information we have obtained from outside verification sources (e.g., Malpractice carriers, board certification and licensing organizations) that are not peer-review protected information.
- The ability to review and correct erroneous information.
- The right to request information on the status of your application.

For inquiries about the mentioned processes, kindly reach out to the Credentialing Coordinators at DDIA via the provided phone number or email address.

- Phone number – 1-800-544-0718
- Email – Provrelations@deltadentalia.com

If you are correcting information that has been submitted, you have thirty (30) calendar days from your application date to correct that information. We will need the corrected information sent to us in writing, preferably by email. The email address for submitting those corrections is: Credentialing@deltadentalia.com.

If you need information on the status of your application, you can contact the DDIA Credentialing Coordinators at Provrelations@deltadentalia.com. DDIA will respond to you within five (5) business days by email with information as to what stage your application is in and if we need additional information or assistance from you and how to contact us.

PROVIDER INFORMATION

Name (First) (Middle) (Last)	Other Known Names(s) (i.e. maiden name, nickname)
Effective Date: (Note: Credentialing can take up to 30 days from receipt of completed application. DDIA will no longer be able to backdate.) ☐ Completion of Credentialing date ☐ Future Effective date:	Are you an Iowa Medicaid Provider? ☐ YES ☐ NO **See note below.*

Individual NPI (Type 1)	Date of Birth	Social Security Number	Gender
Required	***Required***	***Required***	☐ M ☐ F ☐ Prefer not to disclose

Race / Ethnicity: Choose one ☐ *I consent to display on the Provider Directory*

☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ Hispanic or Latino ☐ White ☐ Prefer not to disclose

Dentist email address: ***NOTE: email will not be published on our website or shared with others.***

Please note: *Federal requirements states for DWP and Hawki participation the provider's individual NPI and the office's TIN and Organizational NPI must be enrolled with Iowa Medicaid (IM). To verify enrollment or start new application, please contact IM directly at 800-338-7909, email imeproviderservices@dhs.state.ia.us or visit their website (https://hhs.iowa.gov)*

DEA & CSA REGISTRATION

Do you currently have an active DEA in the state(s) in which you practice? ☐ YES ☐ NO

DEA #	Expiration Date

If "NO":
☐ I refer my patients to their Primary Care Physician or Urgent Care / Emergency Room
☐ _____ will write my prescriptions for me. (Please list Practicing Provider's DEA #: _____)

Do you currently have an active CSA / CDS in the state(s) in which you practice? ☐ YES ☐ NO

CSA #	Expiration Date

If "NO":
☐ I refer my patients to their Primary Care Physician or Urgent Care / Emergency Room
☐ _____ will write my prescriptions for me. (Please list Practicing Provider's CSA #: _____)

LICENSE & EDUCATION

Iowa Dental License #	Expiration Date
List any active, pending, or inactive licenses to practice dentistry in a state other than Iowa:	

Dental School	Graduation Date	Degree
Graduate / Residency Dental Program	Graduation Date	☐ DDS ☐ DMD ☐ MDS ☐ BDS ☐ MSD

Residency / Postgraduate Training

☐ I do not currently have any specialty training.
☐ Endodontist ☐ Oral Surgeon ☐ Orthodontist
☐ Pediatric Dentist ☐ Periodontist ☐ Prosthodontist
☐ Other: _____

Board Certified? ☐ YES ☐ NO
Board Certification Issued By: _____
****Please provide a copy of certification.****

OFFICE / PRACTICE SITE INFORMATION

For additional sites, please utilize Page 7.

Please provide the following information for the primary site at which you practice.

☐ Primary ☐ Secondary ☐ Part-Time ☐ Other (please explain): _____

Practice Location Name	Tax ID Number	Organizational NPI

Address (include suite #, if applicable)

City	State	Zip Code	County

Phone Number	Fax

Is the payment address the same as the treatment office address? ☐ YES ☐ NO

Payment Address (P.O. Boxes are acceptable)	City, State, Zip

General Office Email *(required)* — *Note: Email will be listed on the Provider Directory*

Office Website ☐ *We do not have a website.*

Emergency service line available 24 hours per day / 7 days a week? ☐ YES ☐ NO

If no, is there a phone message when office is closed directing patients where to seek emergency care? ☐ YES ☐ NO

a) Does this office comply with ADA standards (accessible parking spaces, exterior and interior routes, entrances, waiting rooms, public restrooms, and employee work areas)?
☐ YES ☐ NO

c) Free parking? ☐ YES ☐ NO

d) Public transit access? (e.g. bus)? ☐ YES ☐ NO

b) In addition, does this office offer the following?

a. Automated doors ☐ YES ☐ NO

b. Wide entries / operatories to accommodate motorized wheelchairs ☐ YES ☐ NO

c. One or more exam rooms where a patient can be treated in their wheelchair ☐ YES ☐ NO

d. Diagnostic equipment to accommodate patients with disabilities ☐ YES ☐ NO

List languages spoken other than English:

PROVIDER INFORMATION

Office Hours:

a) Open before 8 AM? ☐ YES ☐ NO

b) After 5 PM? ☐ YES ☐ NO

c) Weekends? ☐ YES ☐ NO

a) Telehealth services available? ☐ YES ☐ NO

b) Accepting new Premier and/or PPO patients? ☐ YES ☐ NO

c) Accepting new DWP adult patients? ☐ YES ☐ NO

d) Accepting new DWP Kids patients? ☐ YES ☐ NO

e) Have you completed cultural competency training? ☐ YES ☐ NO

Do you treat disabled children?

a) Physical Disability? ☐ YES ☐ NO

b) Intellectual Disability? ☐ YES ☐ NO

Do you treat disabled adults?

a) Physical Disability? ☐ YES ☐ NO

b) Intellectual Disability? ☐ YES ☐ NO

WORK HISTORY

☐ Check here if you are a new graduate.

Please list your dentist work history for the last 5 years below. Alternatively, you may attach a current Curriculum Vitae. Provide an explanation for any gaps in work history.

From *(MM/YYYY)*	Position		
To *(MM/YYYY)* Current	Employer Name		
Address			
City	State	ZIP	Phone Number
From *(MM/YYYY)*	Position		
To *(MM/YYYY)*	Employer Name		
Address			
City	State	ZIP	Phone Number
From *(MM/YYYY)*	Position		
To *(MM/YYYY)*	Employer Name		
Address			
City	State	ZIP	Phone Number
Work Gap Explanation:			

HOSPITAL AFFILIATION (IF APPLICABLE)

☐ I do not currently have any hospital or facility privileges.

From *(MM/YYYY)*	Facility Name		
To *(MM/YYYY)*	Address		
City	State	ZIP	Phone Number
Admitting Privileges: ☐ YES ☐ NO			
From *(MM/YYYY)*	Facility Name		
To *(MM/YYYY)*	Address		
City	State	ZIP	Phone Number
Admitting Privileges: ☐ YES ☐ NO			

QUALITY FOCUSED QUESTIONS

An explanation is required if you answer "yes" to any of the following questions. For required explanations, use the section below the questions and include the question number, dates, circumstances, and dispositions.

1. Are you **ineligible** for DEA or CSA registrations or has your DEA or CSA certification been denied, revoked, limited, suspended, put on probation, or voluntarily relinquished? *If yes, explanation required.*	☐ YES	☐ NO
2. Have you ever been disciplined by a state dental board? *If yes, explanation required.*	☐ YES	☐ NO
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.*	☐ YES	☐ NO
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.*	☐ YES	☐ NO
5. Has your professional license or privileges in any state ever been denied, revoked, limited, suspended, put on probation, or voluntarily relinquished? *If yes, explanation required.*	☐ YES	☐ NO
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.*	☐ YES	☐ NO
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.*	☐ YES	☐ NO
8. Do you presently use any drugs illegally? *If yes, explanation required.*	☐ YES	☐ NO
9 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 perform the essential functions of the practice of dentistry with or without accommodations? *If yes, explanation required.*	☐ YES	☐ NO

Explanation of Yes Answer(s) | Please attach additional explanation on separate sheet, if needed.

)	
)	
)	
)	

☐ I acknowledge I have reviewed the Fraud, Waste and Abuse Training located on the Dentist Connection under Resources > Education Materials.

☐ I acknowledge DDIA provides American Sign Language and Translation Services at no cost to myself or my patients and that more information is located on the Dentist Connection under Resources > Value-Added Services.

I understand that it is my responsibility to provide correct and complete credentialing information to 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: _____

OFFICE / PRACTICE SITE INFORMATION

For additional sites, please copy Page 7.

Please provide the following information for each additional site at which you practice.

☐ Primary ☐ Secondary ☐ Part-Time ☐ Other (please explain): _____

Practice Location Name	Tax ID Number	Organizational NPI

Address (include suite #, if applicable)

City	State	Zip Code	County

Phone Number	Fax

Is the payment address the same as the treatment office address? ☐ YES ☐ NO

Payment Address (P.O. Boxes are acceptable)	City, State, Zip

General Office Email *(required)* — *Note: Email will be listed on the Provider Directory*

Office Website ☐ *We do not have a website.*

Emergency service line available 24 hours per day / 7 days a week? ☐ YES ☐ NO

If no, is there a phone message when office is closed directing patients where to seek emergency care? ☐ YES ☐ NO

a) Does this office comply with ADA standards (accessible parking spaces, exterior and interior routes, entrances, waiting rooms, public restrooms, and employee work areas)?
☐ YES ☐ NO

c) Free parking? ☐ YES ☐ NO

d) Public transit access? (e.g. bus)? ☐ YES ☐ NO

b) In addition, does this office offer the following?

a. Automated doors ☐ YES ☐ NO
b. Wide entries / operatories to accommodate motorized wheelchairs ☐ YES ☐ NO
c. One or more exam rooms where a patient can be treated in their wheelchair ☐ YES ☐ NO
d. Diagnostic equipment to accommodate patients with disabilities ☐ YES ☐ NO

List languages spoken other than English:

PROVIDER INFORMATION

Office Hours:

a) Open before 8 AM? ☐ YES ☐ NO
b) After 5 PM? ☐ YES ☐ NO
c) Weekends? ☐ YES ☐ NO

a) Telehealth services available? ☐ YES ☐ NO
b) Accepting new Premier and/or PPO patients? ☐ YES ☐ NO
c) Accepting new DWP adult patients? ☐ YES ☐ NO
d) Accepting new DWP Kids patients? ☐ YES ☐ NO
e) Have you completed cultural competency training? ☐ YES ☐ NO

Do you treat disabled children?

a) Physical Disability? ☐ YES ☐ NO
b) Intellectual Disability? ☐ YES ☐ NO

Do you treat disabled adults?

a) Physical Disability? ☐ YES ☐ NO
b) Intellectual Disability? ☐ YES ☐ NO

DELTA DENTAL

DELTA DENTAL PARTICIPATING Hawki ORTHODONTIC SERVICES AGREEMENT

This Delta Dental Participating Hawki Orthodontic Services Agreement ("Agreement") is made by and between Delta Dental of Iowa ("Delta Dental") and the undersigned dentist ("Participating Dentist").

RECITALS:

A. Delta Dental has entered into an agreement with the State of Iowa acting by and through the Iowa Department of Human Services, entitled "Contract for Dental Care Services Under the Healthy and Well Kids in Iowa (Hawki) Program" which, among other things, provides for a limited number of orthodontic benefits if Medically Necessary (as hereinafter defined) criteria is met and are listed in specific Hawki Procedure Codes (as hereinafter defined).

B. Participating Dentist wishes to enter into this Agreement to provide such orthodontic benefits under the Hawki Orthodontic Program (as hereinafter defined).

Participating Dentist represents and agrees as follows:

1. All terms capitalized in this Agreement are defined in this Agreement or in the documents incorporated by reference.

   "Covered Enrollee" means any dental patient eligible for orthodontic benefits under the Hawki Orthodontic Program.

   "Covered Services" means orthodontic services listed in Exhibit A to which a Covered Enrollee is eligible under the Hawki Orthodontic Program

   "Hawki Contract" means the "Contract for Dental Care Services Under the Healthy and Well Kids in Iowa (Hawki) Program" dated January 1, 2005 between the State of Iowa acting by and through the Iowa Department of Human Services and Delta Dental of Iowa, as heretofore and hereafter amended.

   "Hawki Orthodontic Fee Schedule" means the fee schedule for specific limited Hawki Procedure Codes listed in Exhibit A to this Agreement.

   "Hawki Orthodontic Program" means the program which provides to Covered Enrollees a limited number of orthodontic benefits that meet Medical Necessity criteria and are listed in specific Hawki Procedure Codes.

   "Hawki Procedure Codes" means the procedure codes listed in Exhibit A to this Agreement.

   "Medical Necessity" or "Medically Necessary" means a Salzmann Index score of 26 or greater.

2. This Agreement, together with any documents incorporated by reference and made a part hereof, constitutes the entire agreement between me and Delta Dental concerning the Hawki Orthodontic Program.

3. Orthodontic procedures will only be approved for handicapping malocclusions, as defined in the Delta Dental Hawki Orthodontic Program Uniform Regulations.

4. Exhibit A sets forth the Covered Services that require prior authorization from Delta Dental. In the event I do not obtain prior authorization for the Covered Services which require prior authorization, Delta Dental shall have no obligation to make payment to me for such Covered Services, and I will not collect, or attempt to collect, my fees from the Covered Enrollee.

5. I will accept from Delta Dental as payment in full for Covered Services rendered to Covered Enrollees the lesser of: (i) the Hawki Orthodontic Fee Schedule attached to this Agreement as Exhibit A, or (ii) my fees for such Covered Services. I shall not bill the Covered Enrollee for the balance, if any, between my fees for such Covered Services and the Hawki Orthodontic Fee Schedule. Delta Dental may revise the Hawki Orthodontic Fee Schedule from time to time by written notice to me. No such revision shall apply retroactively to dental services provided prior to notice of the revision.

6. Delta Dental shall include my name and address in the Delta Dental directory of Hawki Orthodontic Program Participating Dentists distributed to persons eligible under the Hawki Orthodontic Program.

7. I will abide by all of Delta Dental's rules and regulations concerning the Hawki Orthodontic Program, as well as the Delta Dental Hawki Orthodontic Program Uniform Regulations, all of which are incorporated herein by this reference and made a part hereof. Such rules, regulations, and the Delta Dental Hawki Orthodontic Program Uniform Regulations may be amended from time to time by Delta Dental, and such amendments are also incorporated herein by this reference and made a part hereof.

8. I will abide by all Delta Dental credentialing requirements. I will notify Delta Dental in writing of any non-compliance on my part with the requirements of credentialing pursuant to Section 13 of the Delta Dental Hawki Orthodontic Program Uniform Regulations.

9. I will abide by all applicable laws and regulations. I hold a current license to practice dentistry under Chapter 153, Code of Iowa, and have an office located in the State of Iowa. I have not been excluded from participating in Medicare or Medicaid programs.

10. I will cooperate with utilization, pre-treatment and post-treatment review programs established and implemented by Delta Dental.

11. I acknowledge that I am an independent contractor. None of the provisions of this Agreement are intended to create or to be construed as creating any employee-employer, partnership, joint venture, or agency relationship.

12. Delta Dental is not responsible for any wrongful act on my part. I understand I may not subcontract my rights, duties or obligations under this Agreement, in whole or in part, without the prior written consent of Delta Dental.

13. Delta Dental may amend this Agreement from time to time by providing to me at least sixty (60) days advance written notice of the amendment, which notice shall be effective when placed in the U.S. mail, postage prepaid, addressed to me at my address set forth below. The amendment shall become effective (unless I terminate this Agreement as provided in the following sentence) upon the later of: (i) the end of

such notice period, or (ii) the effective date specified in such notice. If I do not accept Delta Dental's proposed amendment, I may terminate this Agreement by certified mail, return receipt requested, sent to Delta Dental at any time during the thirty (30) day period after the date of Delta Dental's notice of amendment, which termination will be effective as of the date the amendment was to have been effective. Notwithstanding the foregoing, if any amendment is required by law, Delta Dental may elect that such amendment shall become effective immediately upon written notice thereof being placed in the U.S. mail, postage prepaid, addressed to me at my address set forth below.

14. I may terminate this Agreement by giving at least sixty (60) days written notice of termination by certified mail, return receipt requested, sent to Delta Dental. Delta Dental may terminate this Agreement as provided in the Delta Dental Hawki Orthodontic Program Uniform Regulations. This Agreement shall terminate concurrently with any termination of the Hawki Contract or the Hawki Orthodontic Program.

15. This Agreement shall become effective upon written notice to me by Delta Dental of Delta Dental's acceptance.

16. This Agreement applies only to the Hawki Orthodontic Program. This Agreement does not apply to any Delta Dental Premier® Participating Dentist's Agreement or any Delta Dental PPO℠ Agreement Supplement to any Delta Dental Premier® Participating Dentist's Agreement which may now or hereafter be in effect between me and Delta Dental, and any such agreements are unaffected by this Agreement.

Delta Dental and Participating Dentist each hereby 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:	Participating Dentist:
Delta Dental of Iowa on this _____ day of _____, _____. _____ Dental Director, Delta Dental of Iowa _____ President and CEO, Delta Dental of Iowa	Signature _____ (name of Participating Dentist) Print Name _____ Address _____ City/Zip _____ Date _____

DELTA DENTAL®

www.deltadentalia.com

Delta Dental of Iowa
Direct Deposit / Electronic Funds Transfer (EFT)
Authorization Agreement – Instructions and Enrollment Form

Special Notes	If you are also participating in Electronic Remittance Advice (ERA)/835, please contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA.
Where to Submit Completed Enrollment Form	Professional Relations Delta Dental of Iowa 9000 Northpark Drive Johnston, IA 50131 Fax 515-261-5608 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 9000 Northpark Drive Johnston, IA 50131 800-544-0718 Fax 515-261-5608 provrelations@deltadentalia.com
Enrollment Confirmation	Once enrollment processes are complete, Delta Dental of Iowa will notify the provider via email or phone call 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 800-544-0718 or provrelations@deltadentalia.com.

DELTA DENTAL

www.deltadentalia.com

Delta Dental of Iowa Direct Deposit / Electronic Funds Transfer (EFT) Enrollment Form

PROVIDER INFORMATION

Provider 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)

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 (DDIA) receives written notification from me/us of its termination in such time and manner as to afford DDIA 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, 9000 Northpark Dr., Johnston, IA 50131 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 800-544-0718 for further instructions.

REMITTANCE ADVICE DELIVERY

Delivery Option:

❑ E-mail notification with delivery of the Remittance Advice to the website

_____
E-mail to receive direct deposit notification

Delta Dental of Iowa Administrative Use Only:

Date	DDIA Representative Initials	Payee Number
_____	_____	_____

DELTA DENTAL NATIONAL EFT/ERA AUTHORIZATION FORM

Delta Dental of Iowa is making enhancements to allow you to receive Electronic Funds Transfers (EFT) from all Delta Dental Member companies, and not just Delta Dental of Iowa. This solution will simplify electronic payments to participating providers and provide access to Electronic Remittance Advice (ERA) information. This means that all dentists signed up for direct deposit (EFT) can be enrolled in to accepting direct deposit from other Delta Dental member companies instead of receiving a paper check if you opt in to the National EFT/ERA feature by signing below. If you currently receive direct deposit from Delta Dental of Iowa and do not wish to opt into the national solution you do not need to do anything. Your office will continue to receive direct deposit (EFT) from Delta Dental of Iowa.

☐ **Yes, I wish to receive Delta Dental National EFT/ERA**

Email: _____

By marking the above and returning this form with signature, I give consent to Delta Dental of Iowa to provide my direct deposit information to other Delta Dental member companies. I do understand I will continue to receive direct deposit(s)/electronic funds transfers (EFT) from Delta Dental of Iowa with access to Remittance Advice (RA) / Electronic Remittance Advice (ERA).

In consideration for the provision of direct deposit services, by signing below, and notwithstanding any language to the contrary herein, you hereby acknowledge and agree that (i) any information you have provided, including but not limited to, the information you supplied Delta Dental of Iowa under the heading "Banking Information", may be transferred, shared or otherwise provided by us to or with any entity that is an affiliate of Delta Dental, as defined above, with other Delta Dental member companies and their affiliates, and with Delta Dental Plans Association, for use in connection with funds to be deposited to your account, (ii) any election to discontinue enrollment in this direct deposit program will take 45 business days to process, and may not be effective to halt any deposits that were initiated while your enrollment in this direct deposit program was in effect, and (iii) in the absence of gross negligence or willful misconduct, neither we, any of our members and affiliates, other Delta Dental member companies and their affiliates, or Delta Dental Plans Association, will be responsible for any damages, or for any fee, charge or other expense assessed against the Bank Account identified above, in conjunction with this direct deposit program. Further, by signing below, you represent and warrant that (i) all of the information you supplied is true and accurate, (ii), the information provided under the heading "Banking Information," above, identifies a bank account held by the Business you identified above, and (iii) the signatory to this Direct Deposit Enrollment Form ("Form") has all necessary power and authority to execute this Form.

Dentist / Office Name: _____

Address, City, State, Zip: _____

Office Phone Number: _____

Provider Tax ID#: _____ NPI: _____

Authorized Signature: _____ Title: _____

Please mail or fax form back to:

Attn: Professional Relations
Delta Dental of Iowa
9000 Northpark Drive
Johnston, Iowa 50131

Fax: 515-261-5608

Questions?

Contact Delta Dental of Iowa Professional Relations at provrelations@deltadentalia.com or 800-544-0718

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

Print or type. See **Specific Instructions** on page 3.

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 of the person whose name is entered on line 1. 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: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its 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.) See instructions.

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 instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* 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 for Part II, later.

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

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, *later.*

DELTA DENTAL®

OWNERSHIP & CONTROL DISCLOSURE FORM

Delta Dental of Iowa is obligated by law to ensure it is not doing business with a person or entity that has been excluded from participation in government programs.[1] Completion and submission of this form is a condition to participation in any government program. Please complete this form as fully as possible. You must disclose all responsive information you know or should know. You ensure all information is accurate and must immediately report any changes by completing a new form. Thank you.

Entity Name:	Tax I.D. Number:
Individual NPI (if applicable):	Organizational NPI (if applicable):

A. Required Disclosures. Below, providers need to disclose 1) each person or entity that has a direct or indirect[2] ownership or control interest in the above entity, 2) each person who is a managing employee[3] of the above entity, 3) any subcontractor[4] in which the above entity has a direct or indirect ownership of five percent (5%) or more, 4) the family relationship, if any, between those with ownership or control interests in the above entity, 5) any other business entities involved with a government program in which the persons listed below have an ownership or control interest, 6) the ownership of any subcontractor to which the above entity has paid more than $25,000 during the last year, 7) any wholly-owned supplier with which the above entity has any significant transactions during the last 5 years, and 8) any subcontractor with which the above entity has had any significant transactions the last 5 years. **Please use tables on pages 3-4 to disclose the information in response to each category.**

B. Final Adverse Actions. Delta Dental of Iowa is obligated to determine whether any provider, supplier or any owner of any provider or supplier has been the subject of a final adverse action. Such disclosure is required for all persons or entities listed herein and the disclosing entity. All final adverse actions must be reported, regardless of whether the action has been appealed or expunged. You are required to report all final adverse actions within 30 days of the event. A final adverse action means any convictions of criminal offenses related to or arising from any Medicare, Medicaid, or Title XX program, including any felony or misdemeanor convictions. It also includes any revocation, suspension or surrender of any health care-related license or accreditation and any suspension, revocation, exclusion or disbarment from participation in or any other sanction imposed by a federal or state health care program or any federal executive branch procurement or non-procurement program.

On page 4, please list all persons and entities disclosed above and 1) if the person or entity has not had a final adverse action, put an “N” in the “Y or N” box after the name; 2) if the person or entity has had a final adverse action, put a “Y” in the “Y or N” box and provide the requested details.

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[1] 42 C.F.R. § 438.610; 42 C.F.R.§§ 455-104-106; 42 C.F.R. §§ 424.516, 519

[2] Direct ownership includes possession of equity in the capital, stock or profits of entity identified above. Indirect ownership includes an ownership interest in an entity that owns the entity identified above or an ownership interest in any entity that has an indirect ownership interest in the entity identified above.

[3] A managing employee means a general manager, business manager, office manager, administrator, director, or any person who exercises operational or managerial control over the disclosing entity. This includes any independent contractor in such a position. All managing employees at all the disclosing entity’s locations must be disclosed.

[4] Subcontractor means a person or entity to which the disclosing entity as contracted or delegated some management function(s) or responsibility of providing medical care, and any person or entity with which the fiscal agent has entered into an agreement to obtain space, goods or services provided under the Medicaid agreement.

C. Other Affiliations. Does the disclosing entity have any current or previous direct or indirect affiliation[5] with a present or former Medicaid provider? ☐ Y ☐ N. If yes, please identify the Medicaid provider(s) on page 4.

D. Outstanding Debt. Do any of the persons or entities listed part B. above 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 state governments? ☐ Y ☐ N ☐ Unknown. If yes, please identify the person or entity on page 4.

E. Other Sanctions. Have any of the persons or entities listed in part B. above been subject to a payment suspension under a federally-funded health care program, had billing privileges denied or revoked, or been excluded from participation under any federally-funded health care program?

- Payment Suspension: ☐ Y ☐ N ☐ Uknown
- Denied or Revoked Billing Privileges: ☐ Y ☐ N ☐ Uknown
- Excluded: ☐ Y ☐ N ☐ Uknown. If yes to any, please identify the person or entity on page 4.

F. National Provider Identifier (NPI). Do any of the persons or entities listed in part B. share a NPI or Federal Tax Identification number with another provider who has uncollected debt?
☐ Y ☐ N ☐ Unknown. If Yes, please identify the person or entity on page 4.

The disclosing entity certifies that the information submitted on this form is true, accurate and complete to the best of the entity's knowledge; that the disclosing entity has read all entries before signing; the disclosing entity agrees to contact Delta Dental of Iowa within 30 days of any changes in the information herein; the disclosing entity 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 or state law. Thank you very much.

Printed Name of Legal Entity Signatory:	
Signature:	Date:

Please use following pages for disclosures.

[5] Affiliation includes, but is not limited to, direct or indirect relationships between individuals or entities or a combination of the two. Such a relationship includes, but is not limited to, a compensation arrangement, an ownership arrangement, managerial authority over any member of the affiliation, the ability of one member of the affiliation to control the other, or the ability of a third party to control a member of the affiliation.

Please use these tables to complete your disclosures. They reference the parts of this disclosure form above. If you need more space, please copy this form for use.

A.1) OWNERS

Name (Legal and Doing Business)	Address	Social Security or Taxpayer ID Number	Describe Ownership Interest

A.2) MANAGING EMPLOYEES

Name	Date of Birth	Social Security Number	Job Title

A.3) SUBCONTRACTOR OWNERSHIP (5% OR MORE)

Name	Tax ID Number	Address

A.4) FAMILY RELATIONSHIPS

A.5) OTHER OWNED ENTITIES

Name	Fiscal Agent / Medicaid No.	Tax ID Number	Primary Address

A.6) SUBCONTRACTORS PAID $25,000

Name	Tax ID Number	Address

A.7) OWNED SUPPLIER SIGNIFICANT TRANSACTIONS

Name	Tax ID Number	Address

A.8) SUBCONTRACTOR SIGNIFICANT TRANSACTIONS

Name	Tax ID Number	Address

B) FINAL ADVERSE ACTIONS

Name	Y or N	Date	Action Taken	Resolution

C) OTHER AFFILIATIONS

Name of Person or Entity	Primary Address	Tax ID Number	Primary Address

D) OUTSTANDING DEBT

Name of Person or Entity	Primary Address

E) OTHER SANCTIONS

Name of Person or Entity	Primary Address	Type of Sanction

F) NATIONAL PROVIDER IDENTIFIER

Name of Person or Entity	Primary Address	NP or Tax ID Number

DELTA DENTAL®

Delta Dental of Iowa
Hawki Orthodontic Program
Uniform Regulations

1. **Incorporation by Reference**. These Uniform Regulations are incorporated by reference into, and made a part of, the Delta Dental Participating Hawki Orthodontic Services Agreements (the "Agreements") made between Delta Dental of Iowa ("Delta Dental") and Participating Dentists. These Uniform Regulations do not apply to the Delta Dental Participating Dentist Dental Wellness Plan Agreement.

2. Terms Defined.

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

(b) "Covered Enrollee" means any dental patient eligible for orthodontic benefits under the Hawki Orthodontic Program.

(c) "Covered Services" means orthodontic services to which a Covered Enrollee is eligible under the Hawki Orthodontic Program.

(d) "Hawki Contract" means the "Contract for Dental Care Services Under the Healthy and Well Kids in Iowa (Hawki) Program" dated January 1, 2005 between the State of Iowa acting by and through the Iowa Department of Human Services and Delta Dental of Iowa, as heretofore and hereafter amended.

(e) "Hawki Orthodontic Fee Schedule" means the fee schedule for specific limited Hawki Procedure Codes listed in Exhibit A to the Agreements.

(f) "Hawki Orthodontic Program" means the program which provides to Covered Enrollees a limited number of orthodontic benefits that meet Medical Necessity criteria and are listed in specific Hawki Procedure Codes.

(g) "Hawki Procedure Codes" means the procedure codes listed in Exhibit A to the Agreements.

(h) "Medical Necessity" or "Medically Necessary" means a Salzmann Index score of 26 or greater.

(i) "Participating Dentist" means a dentist who holds a current license to practice dentistry under Chapter 153, Code of Iowa, with an office located in the State of Iowa, who has entered into a Hawki Orthodontic Services Agreement.

3. **Acceptance of Covered Enrollees.** Participating Dentists shall accept Covered Enrollees covered by the Hawki Orthodontic Program. Participating Dentists shall abide by all the Delta Dental rules and regulations relating to the furnishing of orthodontic dental services to Covered Enrollees, including these Uniform Regulations, as amended from time to time.

4. **Prior Authorization; Medically Necessary.** The Exhibit As to the Agreements set forth the Covered Services that require prior authorization from Delta Dental. In the event a Participating Dentist does not obtain prior authorization for the Covered Services which require prior authorization, Delta Dental shall have no obligation to make payment for such Covered Services, and the Participating Dentist may not

collect, or attempt to collect, the Participating Dentist's fees from the Covered Enrollee.

Covered Services shall only include orthodontic procedures which are for handicapping malocclusions. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the recipient by causing:

- Impaired mastication,
- Dysfunction of the temporo-mandibular articulation,
- Susceptibility to periodontal disease,
- Susceptibility to dental caries, and
- Impaired speech due to malpositions of the teeth.

Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite, and crossbite. A Salzmann Index score of 26 or greater will be used as criteria for Medically Necessary benefits.

Prior authorization for treatment will be assessed in a manner consistent with "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, DDS, American Journal of Orthodontics, October 1968.

A request for prior authorization shall be accompanied by documentation as required by Delta Dental to substantiate Medically Necessary Covered Services.

Post treatment records shall be furnished to Delta Dental upon request.

Prior authorization may be given for a complete comprehensive case of active orthodontic treatment.

Prior to providing a Covered Enrollee with orthodontic services that are not Medically Necessary, the Participating Dentist shall inform the Covered Enrollee of Delta Dental's payment policies and obtain a written acknowledgement from the parent or legal guardian of the Covered Enrollee that he/she has been informed the dental services will not be paid by Delta Dental.

5. <u>Payment</u>.

(a) Participating Dentist shall be paid according to the terms of the Agreement, including these Uniform Regulations, the Hawki Contract, and the applicable fee schedule and office manual that form a part of the Agreement. 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 Hawki Contract (with respect to Covered Services under the Hawki Contract) and (ii) Delta Dental's criteria for payment.

(b) Participating Dentists shall not bill Covered Enrollees for amounts provided in the Agreement. Participating Dentists shall only bill Delta Dental for such amounts. Covered Enrollees shall, in no circumstance, be liable for money owed to a Participating Dentist by Delta Dental and in no event shall a Participating Dentist collect, or attempt to collect, from a Covered Enrollee, any money owed to the Participating Dentist by Delta Dental.

(c) Delta Dental may elect to pay Participating Dentists prior to the completion of orthodontic services. In the event the orthodontic services are not completed for any reason, a Participating Dentist shall refund to Delta Dental a prorata portion of the fees paid to the Participating Dentist, which prorata portion will be based on the amount of the orthodontic services rendered to the Covered Enrollee.

(d) Payment for services provided under the Hawki Contract will be limited to Participating Dentists that have contracted with Delta Dental under the Hawki Orthodontic Program Dentist's Agreement and who have also enrolled with Iowa Medicaid Enterprise ("IME") as a Medicaid provider. No payments under the Hawki Contract will be made to the Participating Dentist after July 1, 2018 unless the Participating Dentist has enrolled with IME.

(e) Notwithstanding the foregoing or anything in the Agreement or in these Uniform Regulations 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 in connection with the Hawki Contract to the extent Delta Dental does not receive payment therefor from IME.

(f) All Covered Services shall be provided to Covered Persons under the Hawki Contract with the same quality and accessibility in terms of timeliness, duration and scope as provided to Participating Dentist's other patients. Participating Dentist shall comply with all of the terms and conditions of the Hawki Contract if Participating Dentist provides Covered Services to Covered Persons under the Hawki Contract.

(g) 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 Covered Services and Participating Dentist's compliance with the terms and conditions of the Agreements, these Uniform Regulations, 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 Persons 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 Agreements and for a period of not less than seven (7) years from the date of termination of the Agreements (or such longer period of time as required by law).

7. **Non-Liability Of Delta Dental.** Delta Dental shall not have any liability for the wrongful or negligent acts or omissions of any Participating Dentist arising from or in any way connected with the dentist-patient relationship.

8. **Claims Filing.** Participating Dentists shall file claims for all Covered Services furnished to Covered Enrollees at no charge to Delta Dental or the Covered Enrollee. Claims shall be submitted 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.

9. **In-Office Records Verification**. Delta Dental may make periodic examinations of a Participating Dentist's office (including, without limitation, the records required to be maintained under Section 6 of these Uniform Regulations) during regular office hours to examine all patient records of Covered Enrollees for the purpose of conducting reviews to determine that charges for Covered Services provided to Covered Enrollees are in accordance with the Participating Dentist's Agreement, and to determine that Covered Services are Medically Necessary.

10. **Recoupment; Overpayments.** In the event Delta Dental makes payments to a Participating Dentist and the payments are later determined to have been made in error, or were for dental services not Covered Services because they were not Medically Necessary, or because of the Participating Dentist's error, Delta Dental's error, or overpayment by Delta Dental, or because the Participating Dentist owes Delta Dental a prorata portion of a fee under Section 5(c) above, or a patient's ineligibility for coverage, Delta Dental may deduct from future payments due the Participating Dentist amounts equal to the amount of the incorrect or unearned payments. Nothing in this Section 10 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.

Participating Dentist shall within forty-five (45) days after Participating Dentist has identified an overpayment hereunder, in accordance with Delta Dental mechanisms and policies that may be established from time to time, report and return the overpayment to Delta Dental, indicating the reason for the overpayment and providing such other information with respect to the overpayment as Delta Dental may request.

11. **Coordination of Benefits**. Benefits shall be coordinated with any other coverage the Covered Enrollee may have available to pay Covered Services. In the event a Covered Enrollee is retroactively enrolled in Medicaid, the Hawki Orthodontic Program shall be the primary payor. If a Covered Enrollee is enrolled with other health or dental benefit coverage, the other benefit plan shall be the primary payor and the Hawki Orthodontic Program shall be the payor of last resort.

12. **Confidentiality.** All dental records containing specific patient information disclosed to Delta Dental shall be considered confidential to the extent required by the 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 Dentists 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 (IDB) regulations.

13. **Availability of Services**. For dentists participating with the Hawki program, emergency services must be available 24 hours per day, 7 days per week. When the dental office is not open, there must be information on where to seek such services (I.e. – answering machine informing members that the office is closed and they can seek emergency care at another named provider's office or a named urgent care/emergency department.

14. **Credentialing; Quality Assurance.** Participating Dentists shall furnish Delta Dental necessary credentialing information, including professional application and profile information, to assist Delta Dental in its evaluation of the Participating Dentist's dental practice. Participating Dentists shall provide the following credentialing elements: (i) an accurate and complete Professional Application and Credentialing Form at least every four (3 years; (ii) an active state-issued dental license; (iii) 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, including, without limitation, any exclusion under any applicable government list; (v) disclosure of any licensing board actions, malpractice claims and other adverse personal matters; and (vi) compliance with Occupational Safety and Health Administration requirements and Centers for Disease Control recommended infection control guidelines. Participating Dentists shall notify Delta Dental immediately of any changes to this credentialing information. All of the Participating Dentist's rights and Delta Dental's obligations under the Agreements and 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.

15. **Discrimination**. Participating Dentists 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, place of residence, physical or mental disability, political belief, sexual orientation or health status. In addition, a Participating Dentist may not discriminate based on payment policies of Delta Dental or against Covered Enrollees who are participants in a program such as under the Hawki Contract.

16. **Compliance with Rules and Regulations**. Participating Dentists shall abide by all Delta Dental rules and regulations. Such rules and regulations include, but are not limited to, those rules and regulations governing credentialing, quality assurance and utilization management. A Participating Dentist shall conduct the Participating Dentist's practice in accordance with the principles and ethics of the American Dental Association and the IDB. Participating Dentists 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.

17. **Communications**. A 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 which may have an adverse affect on Delta Dental. Participating Dentist shall not materially 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.

18. **Safety and Hygiene**. Participating Dentists 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 Participating Dentist's 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.

19. **Changes in Participating Status**. Delta Dental may notify Covered Enrollees when a Participating Dentist's Agreement is terminated. The Participating Dentist must notify Covered Enrollees who have been patients of the Participating Dentist in the event the Participating Dentist's Agreement is terminated prior to additional services being rendered. A copy of any written communication from Delta Dental to a Covered Enrollee regarding a termination of a Participating Dentist's Agreement will be provided to the Participating Dentist. Similarly, a copy of any written communication from the Participating Dentist to a Covered Enrollee regarding a termination of the Participating Dentist's Agreement shall be provided to Delta Dental.

20. **Amendments to Uniform Regulations**. Delta Dental may amend these Uniform Regulations and other rules and regulations from time to time. If an amendment to these Uniform Regulations, the Delta Dental Office Manual or other rules and regulations is required by applicable law, the amendment shall become effective when required by applicable law, and Participating Dentists shall be given notice of such amendment within sixty (60) days (except in the case of the Delta Dental Office Manual, which shall be within thirty (30) days), unless such notice is impractical, in which case notice will be given as soon as is practical. Except as provided above. Participating Dentists shall be given notice of any amendment of these Uniform Regulations or other rules and regulations and such amendments shall become effective the later of: (i) sixty (60) days from the date of Delta Dental's notice, or (ii) the effective date specified in such notice.

21. **Notices of Termination; Other Notices**. Any notice of termination ("Notice of Termination") required or permitted to be given to a Participating Dentist under these Uniform Regulations shall be in writing and shall be deemed given when delivered personally, placed in the U.S. mail (postage prepaid) and sent certified or registered, return receipt requested, or delivered to a recognized overnight courier service for next day delivery (delivery charges prepaid), and addressed to the Participating Dentist at the address set forth on the Participating Dentist's Agreement, or to such other address for Notices of Termination as provided in writing to Delta Dental by the Participating Dentist. Any other notices to Participating Dentist under these Uniform Regulations shall be effective as of the date set forth in such notice upon placing the notice in the U.S. mail (postage prepaid) addressed to the Participating Dentist at the address set forth on the Participating Dentist's Agreement, or to such other address for such notices as provided in writing to Delta Dental by the Participating Dentist.

22. **Termination of Participating Dentist's Agreement Without Cause by Delta Dental.** Delta Dental may terminate a Participating Dentist's Agreement at any time by sending a Notice of Termination, which termination will be effective sixty (60) days or more after the date of such Notice of Termination, as designated in the Notice of Termination.

23. **Termination of Participating Dentist's Agreement For Cause by Delta Dental.** Delta Dental may terminate a Participating Dentist's Agreement for cause if the Participating Dentist violates any of the provisions of the Participating Dentist's Agreement or these Uniform Regulations, the Participating Dentist is guilty of unprofessional conduct, the Participating Dentist's license to practice dentistry issued by the IDB is suspended or terminated, other sanctions issued by the IDB, lack of adherence to published national clinical dental standards, or the Participating Dentist is guilty of any other conduct that could be detrimental to Delta Dental or Covered Enrollees. Any such termination shall be effective on the date designated by Delta Dental in the Notice of Termination (which may be immediate), as determined by Delta Dental. 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.

24. **Reasons for Not Terminating**. A Participating Dentist shall not be terminated for cause for the sole reason that the Participating Dentist expressed disagreement with Delta Dental's decision to deny or limit benefits, or sought reconsideration of treatment, or discussed with a Covered Enrollee alternative methods of treatment.

25. **Termination of a 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 who 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 ("Notice of Appeal") by certified mail, return receipt requested to the Chief Executive Officer at Delta Dental's address. A Notice of Appeal must be received by Delta Dental within thirty (30) days from 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 request a hearing within the specified time shall constitute a waiver of the Participating Dentist's right to the hearing and subsequent review and appeal.

(c) **Appeal May Stay Termination.** Upon receipt of a timely sent written Notice of Appeal, the Chief Executive Officer may, but is not required to, stay the termination of the Participating Dentist's 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 of 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 will not be more than thirty (30) days after such notice to 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 reporter 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 of 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 from 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 of 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 by certified mail, return receipt requested, 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 of the Board of Directors, 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 24(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. 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 for the conduct of the hearing by the Board of Directors shall be a quorum thereof as provided in the Bylaws of Delta Dental.

(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 agents and employees, arising out of or in the conduct of appeals pursuant to this Section 23.

26. Waiver of Jury Trial. In consideration of Delta Dental's acceptance of a Participating Dentist's Agreement, Delta Dental and Participating Provider irrevocably and unconditionally waive all right to trial by jury in any action, proceeding or counterclaim arising out of or relating to these Uniform Regulations.

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