PREMIER ACCESS

DENTIST AGREEMENT

THIS AGREEMENT is made and entered into by and between PREMIER ACCESS INSURANCE COMPANY, a California Corporation ("PREMIER") and the undersigned Dentist, licensed to practice dentistry in the state noted on the signature page ("DENTIST").

WHEREAS, PREMIER has developed a participating provider organization ("PPO") to provide professional dental services through individual and group contracts ("DENTAL PLANS") with employee groups, unions, corporations, insurance companies, dental claim administrators, government agencies and other payors ("Payors") and to make such dental services available to eligible employees or members of such groups and their covered dependents ("Covered Individuals"), and

WHEREAS, PREMIER agrees to make available to Covered Individuals the name, address and telephone number of DENTIST, and

WHEREAS, DENTIST is willing to provide the Dental Services under the terms and conditions set forth below.

NOW, THEREFORE, in consideration of the promises and mutual covenants contained in this Agreement and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is mutually covenanted and agreed as follows:

1. **DENTAL SERVICES:** Dentist agrees to render dental services ("Dental Service") to Covered Individuals, all in accord with PREMIER's policies, as specified in Premier's Dentist Handbook. Dentist agrees not to discriminate or differentiate in the treatment of Covered Individuals based on color, creed, age, sex, marital status, religion, or otherwise.

2. **FEES:** DENTIST agrees to charge Covered Individuals no more than the amounts set forth in the attached Exhibit A (fee schedule) as payment in full for services rendered under the scope of the AGREEMENT. Further, DENTIST agrees that any services not listed in the Maximum Fee Schedule be provided at the DENTIST's Usual and Customary Rate (UCR) for such dental services. The fee schedule in Exhibit A will apply even if the applicable Dental Plan is secondary for purposes of coordination of benefits.

3. **BILLING:** Billing shall include detailed and descriptive dental and patient data and identifying information on forms approved by PREMIER and DENTIST agrees to adhere to billing guidelines as specified in Premier's Dentist Handbook. DENTIST shall look solely to the applicable Payor for such compensation and shall not seek compensation from Covered Individuals, except for applicable co-payments, deductibles or services not covered under the applicable Dental Plan. DENTIST understands that presentation of a Premier Identification Card by any person is not a guarantee that the person is a Covered Individual and entitled to benefits on the date of service. DENTIST understands that payments for services are made for Covered Individuals who are eligible on the date of service, as determined by PREMIER's eligibility department.

4. **ELECTRONIC TRANSFER OF FUNDS AND PAYMENT / BENEFIT DATA:** In 2009, PREMIER intends to implement an electronic payment process whereby it will pay dental claims electronically by transferring funds to DENTIST'S designated bank account. Therefore, once implemented, DENTIST agrees to receive claim payments electronically from PREMIER in such bank account as DENTIST specifically designates in writing. Once the electronic transfer of funds payment process is implemented, DENTIST also agrees to receive his or her patient's explanation of benefits and any other communication from PREMIER by facsimile or other electronic means available to DENTIST. If, however, DENTIST elects to receive claim payments and various patient communications by mail, DENTIST shall notify PREMIER in writing.

   Other Payors that utilize Premier's dental network may continue to utilize or request that claim payments and other information be transmitted solely by mail. If requested by a Payor, DENTIST agrees to continue to receive claim payments and patient information from those Payors through the mail.

5. **PROVIDER DISPUTE RESOLUTION MECHANISM**: If any dispute arises between PREMIER and DENTIST, the party challenging, appealing, or requesting reconsideration of a decision or a billing determination or other contract dispute shall provide written notice to the other party. The notice shall specify the basis for the dispute.

6. **COMPLAINTS:** DENTIST agrees to cooperate with and provide PREMIER with all information necessary to resolve Covered Individual's grievances with respect to Dental Services.

7. **QUALITY ASSESMENT/UTILIZATION REVIEW:** DENTIST agrees to participate in and adhere to the quality assessment and utilization review programs of PREMIER. DENTIST further agrees that payments will be made by applicable Payor only for Dental Services rendered in accordance with the quality Assessment/Utilization Review Program.

8. **LIABILITY FOR TREATMENT OR SERVICE:** DENTIST solely shall be responsible to Covered Individuals for treatment or service. Nothing in this Agreement is intended to create, nor shall it be construed to create, any rights to PREMIER to intervene in any manner with, nor shall it render them responsible for, the method or means by which DENTIST renders treatment or service to Covered Individuals.

9. **DENTIST'S LICENSURE, INSURANCE AND INDEMNIFICATION:** DENTIST shall, at his/her sole expense, meet and continue to meet, all applicable regulations relating to professional licensing, including without limitation, continuing dental education requirements. This agreement shall terminate immediately if DENTIST's license to practice dentistry is suspended, revoked or nullified in any state in which he/she practices. DENTIST, at his/her sole cost and expense, shall procure and maintain such policies of general and professional liability and other insurance as necessary to insure DENTIST and DENTIST's employees against any claim for damages arising by reason of personal injuries or death occasioned directly or indirectly by the performance of Dental Service by DENTIST. Memorandum copies of such policies shall be delivered to PREMIER upon request. The insurance coverage will be in effect prior to the effective date of the Agreement. DENTIST will give PREMIER thirty (30) days advance written notice of the termination of such policies. Termination of such policies will cause this Agreement to immediately terminate. The coverage amount of insurance shall be no less than Five Hundred Thousand Dollars ($500,000) per incident or occurrence and One Million Dollars ($1,000,000) in aggregate coverage. DENTIST shall indemnify, protect, defend and hold PREMIER and all payors, and their officers, shareholder, directors, employees and agents harmless for, from and against any and all claims, demands, liabilities, losses, damages, judgments, costs, taxes and expenses sustained or incurred by any one in connection with any action or omission of DENTIST.

10. **ROSTER**: DENTIST agrees that PREMIER may use DENTIST'S name, address, telephone number, and descriptions of care and specialty services in any roster of participating Dentist. Upon termination of this agreement, PREMIER will remove DENTIST'S information from future published directories.

11. **MEMBER COPAYMENTS AND DEDUCTIBLE:** DENTIST agrees not to waive any Covered Individuals copayments or deductible. DENTIST acknowledges that waiving Covered Individuals copayments and deductible does cause substantial financial harm to PREMIER and PREMIER has the right to recoup losses from DENTIST.

12. **INSPECTION OF RECORDS:** DENTIST and PREMIER agree that all Covered Individual records will be available for review by PREMIER during business hours upon prior notification by PREMIER to the DENTIST. It is further agreed that all records will be treated as confidential so as to comply with all state and federal laws regarding their confidentiality.

13. **COMPLIANCE WITH LAW:** DENTIST shall conduct his/her/its professional practice and supervise all personnel in a manner that complies with all applicable laws, and shall maintain all necessary permits, certificates and licenses in good standing. DENTIST shall promptly notify PREMIER of any complaints and any disciplinary actions taken based upon DENTIST'S practices or the practices of any other partner or shareholder of DENTIST. DENTIST hereby authorizes any government agency regulating or supervising the practice of dentistry to release to PREMIER information relating to any such complaints or disciplinary actions.

14. **LANGUAGE ASSISTANCE PROGRAM:** Dentist shall comply with Premier's language assistance program it has developed pursuant to Section 1367.04 of the Knox-Keene Health Care Service Plan Act of 1975, as amended, and Title 28, California Code of Regulations, Section 1300.67.04.

15. **TERM OF AGREEMENT, TERMINATION:** The initial term of this Agreement shall end one year from the date the contract was signed. The Agreement will automatically renew for subsequent 12 month periods unless terminated by PREMIER or DENTIST. Either party may terminate this agreement for any reason or no reason without cause by giving written notice to the other party at least 60 days prior to the date of termination. In the event this Agreement is terminated, DENTIST will provide Dental Services under the terms of this Agreement as if it had not terminated for any dental condition for which treatment has begun as of the termination date until all necessary Dental Services for each condition have been completed.

16. **ARBITRATION:** All disputes, controversies, or claims arising out of or relating to the interpretation of this Agreement shall be settled by final and binding arbitration in accordance with the Commercial Arbitration Association, to the extent such rules are not inconsistent with this Agreement. Any award rendered by the arbitrators shall be final and binding upon the parties hereto, and judgment upon any such award may be entered in any court having jurisdiction thereof. The fees and expenses of the arbitrators shall be borne equally by the parties. Each party shall pay its own fees and costs relating to any arbitral proceedings, including attorney's fees.

17. **HEADINGS**: The headings of paragraphs contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

18. **WAIVER OF BREACH:** Waiver of a breach of this Agreement shall not be deemed to be a waiver of any other breach or of the same breach at a later time.

19. **ASSIGNMENT:** DENTIST may not assign or transfer any of his/her rights or obligations hereunder, without the prior written consent of PREMIER.

20. **RELATIONSHIP OF THE PARTIES:** The relationship between DENTIST and PREMIER shall be that of two independent entities contracting with each other at arm's length. Neither party shall be deemed the agent of the other and no joint venture or partnership shall result from this Agreement.

21. **NOTICE:** Any and all notices required to be given pursuant to the terms of this Agreement must be given by United States mail, postage prepaid return receipt requested, and forwarded to the following address or other such as either party may in writing submit.

If to PREMIER

Provider Relations Coordinator
Premier Access Insurance Company
8890 Cal Center Drive
Sacramento, CA 95826

If to DENTIST

Name

Address

IN WITNESS WHEREOF, the parties have executed and entered into this Agreement as of the day and year set forth on this page.

PREMIER ACCESS INSURANCE COMPANY

by:

Title: Vice President, Plan Administration

Date:

DENTIST

by: _____
(Dentist Signature)

Print Name: _____

Tel. Number (include area code):

Date: License #:

PREMIER ACCESS

PROVIDER INFORMATION

Please type or print clearly.

BILLING DENTIST'S INFORMATION

BILLING DENTIST: Title ☐ D.D.S ☐ D.M.D.

Specialty: ☐ Endodontist ☐ Oral Surgery ☐ Orthodontist ☐ Pedodontist ☐ Periodontist ☐ Prosthodontist

Last Name | First Name | Middle Initial | Gender ☐ Male ☐ Female

Date of Birth | Social Security # | License # | NPI Number

Dental School Name | Year Graduated | DEA #

Indicate areas of special dental training or interest:

BOARD STATUS Are you Board Certified? ☐ NO ☐ YES If no, are you or have you been Board Eligible? ☐ No ☐ Yes

Year of Board Certification *(if applicable)*

PROFESSIONAL LIABILITY INSURANCE FOR LAST 5 YEARS *(use a separate sheet if necessary)*. IMPORTANT: Please attach a copy of current malpractice insurance cover page(s) showing name and address of carrier, doctor's name, expiration date, and limits of liability.

Carrier | Policy # | Limits | Exp. Date

HOSPITAL ADMITTING PRIVILEGES: Do you have hospital privileges? ☐ NO ☐ YES *(please complete below)*

Hospital Name | Address | Phone

PRACTICE INFORMATION

Practice Name | Phone | Fax | NPI Number

Address | City | State | Zip Code

Mailing Address *(if different from above)* | City | State | Zip Code

Principal Owner(s) | Foreign Languages Spoken *(list in order of fluency):*

Legal Entity *(check one)* ☐ Corporation ☐ Partnership ☐ Sole Proprietor Tax ID Number (TIN) or Employer ID Number (EIN)

Office Staff (indicate in FTEs): Dentists: Hygienists: Assistants: Receptionists: Operatories:

Office Hours: Mon: Tues: Wed: Thurs: Fri: Sat: Sun:

ASSOCIATE DENTIST(S) INFORMATION

Name			Gender					
Last	First	Middle	F	M	Specialty	Board Certified?	License #	NPI #

PREMIER ACCESS

CONFIDENTIAL INFORMATION

NOTE: Any "Yes" answer to the following questions requires that you supply a brief explanatory statement. Please us a separate sheet if necessary. Your answers to the questions below must represent the billing dentist and any associate dentist information at the practice.

1. Are you now or have you ever been involved in any malpractice suit or arbitration, or has any settlement ever been paid by you or paid on your behalf? ☐ YES ☐ NO

   IF YES, please explain for each suit, arbitration, or settlement (whether open or closed) all details including dates of incidents, fillings, settlements; underlying circumstances; your role and legal status (defendant, co-defendant, other); subsequent events (including patient outcome); professional liability insurer involved; amounts paid, current status, and total numbers. ☐ Total Numbers
2. Has your professional liability insurance ever been denied, suspended, canceled, or not renewed? ☐ YES ☐ NO
3. Have you ever had any one of the following items denied, revoked, suspended, not renewed, placed on probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items: ☐ YES ☐ NO
   - State license ☐ YES ☐ NO
   - DEA, CDS, or other applicable narcotic registration ☐ YES ☐ NO
   - Hospital or other health-care facility staff membership or privileges ☐ YES ☐ NO
   - Professional organization membership ☐ YES ☐ NO
   - Medicaid or other government program participation ☐ YES ☐ NO
   - HMO, PPO, or other managed care plan ☐ YES ☐ NO
   - Employment as a health-care provider by a military service, hospital, HMO, or other health-care organization ☐ YES ☐ NO
4. Do you have any physical or mental impairment or condition that, with or without accommodation, would make you unable to perform the essential functions of a practitioner in your area of practice or unable to perform such essential functions without a direct threat to the health and safety of others? ☐ YES ☐ NO
5. Considering the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that could pose a significant health and safety risk to your patients? ☐ YES ☐ NO
6. Within the past five years up to and including the present, have you ever had a chemical dependency or substance abuse problem that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? ☐ YES ☐ NO
7. Have you ever been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime? ☐ YES ☐ NO
8. Have you ever been subject to any peer-review type of action? ☐ YES ☐ NO

REQUIRED SUBMISSIONS

I authorize Premier Access Insurance Company to consult with professional liability carriers, and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics and other qualifications. I, the undersigned, thereby certify that the information requested by Premier Access is truthful, correct and complete in all respects, and I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating dentist with the dental plan. The undersigned hereby agrees to notify Premier Access Insurance Company of any changes in the above information. I here by authorize Premier Access Insurance Company to initiate claims payments through automatic bank deposits and, if necessary, adjustments to my account for payments made in error. If DENTIST elects to receive claim payments and various patient communications by mail, DENTIST shall notify PREMIER in writing.

Dentist's Signature *(no signature stamps)* _____ Date _____

Please send the following items with the agreement:

Readable Copies of your
- ☐ Wallet-size Dental License
- ☐ Malpractice Insurance Declarations Page
- ☐ Board Certification (if applicable)
- ☐ Specialty Certificate (if applicable)

Original
- ☐ Signed Provider Contract
- ☐ Completed Provider Credential Information
- ☐ Completed W9 form

PREMIER ACCESS

ELECTRONIC DIRECT DEPOSIT

Checking Account Information

Account Name:

Account Number:

Bank Name:

Bank Address:

Bank Routing Number (ABA):

To ensure proper registration of your electronic deposit, please include a voided check.

PLEASE COMPLETE IF YOU HAVE MORE THAN ONE LOCATION

Please provide the information for other locations that you intend to participate. Please copy this page if you have more than two locations.

PRACTICE INFORMATION

Practice Name | Phone | Fax | NPI Number

Address | City | State | Zip Code

Mailing Address *(if different from above)* | City | State | Zip Code

Principal Owner(s) | Foreign Languages Spoken *(list in order of fluency):*

Legal Entity *(check one)* ☐ Corporation ☐ Partnership ☐ Sole Proprietor | Tax ID Number (TIN) or Employer ID Number (EIN)

Office Staff (indicate in FTEs): Dentists: | Hygienists: | Assistants: | Receptionists: | Operatories:

Office Hours: Mon: | Tues: | Wed: | Thurs: | Fri: | Sat: | Sun:

PRACTICE INFORMATION

Practice Name | Phone | Fax | NPI Number

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