

TOTAL DENTAL ADMINISTRATORS HEALTH PLAN, INC.
2111 E. Highland Avenue, Suite 250, Phoenix, AZ 85016 ♦ (602) 266-1995 or 1-888-422-1995

Provider Membership Application
Plans applying for PPO _____ DHMO _____ Dental Eclipse _____

Confidential

Dental Office Name: _____

Doctor: _____

Address: _____

Email address: _____

Phone Office: () _____ fax: () _____

Office Contact/Manager: _____

Doctor's Date of Birth: _____

Doctor's Social Security Number: _____

Doctor's NPI Number: _____

College(s) Attended*: _____

_____ (Date) _____ (Degree) _____

Dental School Attended: _____

_____ (Date) _____ (Degree) _____

Other Graduate Training(s): _____

_____ (Date) _____ (Degree) _____

Type of Practice: Sole Proprietor Partnership

Corporate Group

Participating Provider Status: General Dentist

Specialist _____

What Patient Recall system do you have in place?:

Postcard Phone Call Scheduled Appointment

Associates: _____ Degree(s) _____

_____ Degree(s) _____

Hygienist: _____ Degree(s) _____

Average number of patients per month: _____

Years at current location: _____ previous: _____

Number of ops: _____ In house lab Yes No

Office hours: _____

Saturday hours: _____ Evening hours: _____

Emergency Service Capability: _____

State License Number _____ Expiration Date _____

Tax ID Number _____ Expiration Date _____

DEA _____ Expiration Date _____

Plans for relocation/expansion (if any): _____

Has your license ever been suspended or revoked?

Yes No

If so, give reason and date(s): _____

Have you ever been bonded? Yes No If yes, by whom? _____

List experience or membership in other Managed Care Dental Plans, Prepaid or DMOS;

List membership in all professional associations and societies: _____

On a separate sheet, list any other special qualifications which you feel will assist the Board in reviewing your application.

I verify that the above information is accurate and true. I understand that my application is not an agreement nor does completion of the application entitle me to provide care for participants as a TDAHP Provider.

Signature of Applicant _____

** Please include the following for each dentist in your office.

1. Application
2. Copy of Dental License
3. Controlled Substance Registration (DEA)
4. Mal practice insurance
5. Form W-9

TOTAL DENTAL ADMINISTRATORS, INC.
PROVIDER AGREEMENT
2111 E. Highland Avenue, Suite 250, Phoenix, AZ 85016 (602) 266-1995

This agreement is entered into by and between Total Dental Administrators, Inc. (hereinafter "TDA") and _____ (hereinafter referred to as "Provider").

I. DEFINITIONS

1. **Participant:** An individual who has enrolled in the TDA, Inc. PPO Plan.
2. **Provider:** An individual, partnership, professional corporation, their agents, employees who are lawfully licensed under the laws of the State where the dental services are rendered and who shall provide professional dental services to Participants at their respective offices, under terms of this Agreement.
3. **Dental Services:** Those professional dental services to eligible Participants under a dental program which accesses by Agreement with TDA, Inc. the TDA-PPO.
4. **Fee Schedule:** The schedule of procedures and applicable fees is attached hereto. Any procedures not listed may be covered and the applicable fees will be determined by TDA in the same manner used to establish the attached schedule of procedures and fees.

II. DUTIES AND OBLIGATIONS OF PROVIDER

1. PROVIDER agrees to accept the Fee Schedule for Dental Services by TDA, Inc. as payment in full for all Participants.
2. PROVIDER hereby agrees to provide professional dental services to Participants which shall be identical in all respects to those dental services rendered to non-participants.
3. PROVIDER shall provide all dental services, equipment, supplies, staff, billing and collection procedures necessary to provide dental services to Participants.
4. PROVIDER agrees to defend, indemnify and hold TDA harmless from and against any claim, lawsuit, liability, damages, judgement and cost of litigation including attorney's fees arising out of such PROVIDER'S negligence, malpractice, errors or omissions in providing dental services and/or products, except to the extent that TDA's insurer provides insurance coverage for the act or omission complained of.
5. PROVIDER shall maintain a valid current policy of professional liability insurance acceptable to TDA and will supply TDA with a certificate of insurance. Further, PROVIDER agrees to immediately notify TDA with respect to any impending change, cancellation, or other modification of such insurance.
6. PROVIDER covenants and agrees not to use or disclose the identity of Participants or TDA's name or goodwill, or any other confidential and/or trade secret information which PROVIDER has received or acquired as a result of this Agreement, nor solicit, divert, or assist any other person or entity in soliciting or diverting any Subscriber or Participant to leave the program.
7. PROVIDER will complete dental treatment of a Participant in accordance with the terms hereof, or at the Participants request transfer records and x-rays to another Provider in the event this Agreement is terminated.
8. PROVIDER will cooperate and participate in the Peer Review and Quality Assurance programs established by TDA.

III. DUTIES AND OBLIGATIONS OF TDA

1. TDA shall require all contracting carriers of TDA-PPO to issue to all Participants identification cards and initial service cards which will enable PROVIDERS to identify Participants enrolled in the PPO Plan. TDA agrees that PROVIDER shall have the right to require Participants to display such identification cards prior to performing dental services; and the right to contact Participants' Plan for eligibility and benefit verification.

2. TDA shall periodically publish and provide to Participants a listing of the name, address, and area(s) of practice of PROVIDER.
3. TDA shall upon reasonable notice and at the PROVIDER'S office, review and photocopy records of such procedures which will allow TDA to effectively monitor compliance of PROVIDER with the PPO Plan.
4. TDA agrees to defend, indemnify and hold PROVIDER harmless from and against any claim, lawsuit, liability, damages, judgement and cost of litigation including attorney's fees arising out of acts of TDA, except to the extent that PROVIDER'S insurer provides insurance coverage for the act of omission complained of.

IV. TERMS OF AGREEMENT

1. This Agreement shall begin on the date designated below and shall remain in effect for one (1) year and be automatically renewed from year-to-year thereafter, subject to cancellation by either party without cause upon the giving of ninety (90) days written notice to the other.
2. This Agreement shall also automatically terminate upon the violation of any of the terms of this Agreement.

V. ASSIGNMENT

1. **Independent Contractor:** Nothing contained herein shall be construed to create the relationship of employer/employee, partner, joint ventures or principal/agent between the parties hereto. PROVIDER shall be and remain an independent contractor, solely responsible for its employees and agents and TDA, Inc. will not interfere or control, in any manner, the rendering of dental services by PROVIDER or his agents. PROVIDER will be solely responsible for the quality of treatment provided to Participants.
2. **Governing Law:** This Agreement shall be governed by and construed in accordance with the laws of the State of Arizona.
3. **Non-Exclusivity:** This Agreement does not prevent PROVIDER from entering into similar PROVIDER agreements with other organizations which offer a program similar to the PPO Plan.
4. **Separability:** Each provision of this Agreement shall be considered separable and, if for any reason, any provision shall be deemed invalid, void, unenforceable or contrary to any existing or future law, such invalidity shall not impair the operation of or affect those provisions of this Agreement which are valid.
5. **Amendment:** This Agreement may not be modified, amended, or changed without the prior written consent of all parties hereto.
6. **Entire Agreement:** This Agreement, including the appendix and fee schedule, set forth all the representations, promises, agreements and understandings between the parties hereto. This Agreement may be executed in several counterparts, each of which shall be deemed to be an original copy of all which together shall constitute one agreement binding on all parties hereto.
7. **Notices:** All notices required or contemplated under this Agreement shall be in writing and shall be sent by certified mail, postage prepaid, addressed to the other party at the address on the signature page hereof.

IN WITNESS WHEREOF, the parties hereunto have affixed their signatures and seals on the day first above written.

PROVIDER:
By: _____
Date: _____
Name/Address (Please Print)

TOTAL DENTAL ADMINISTRATORS, INC.
By: _____
Date: _____

Additional Office Locations: _____

Phone #: () _____
Specialty: _____
Tax I.D. or Social Security #: _____