DELTA DENTAL®

Participation Application Checklist

Thank you for your request to become a Delta Dental participating provider. Complete all forms in their entirety and **email them to ProviderRelations@deltadentalva.com** or fax to 540.491.9709. All items included in this packet are listed below for your convenience:

- ☐ Completed and signed Individual Practitioner Profile
- ☐ Legible copy of Drug Enforcement Administration license (Controlled Substance Registration Certificate) or signed statement
- ☐ Proof of professional malpractice insurance
- ☐ Proof of Anesthesia Education and ACLS certificates, if applicable
- ☐ Five year work history
- ☐ National Provider Identifiers (NPIs)
- ☐ Facility Profile
- ☐ Signed Delta Dental Premier® Participating Dentist Agreement
- ☐ Signed Delta Dental PPO™ Participating Dentist Agreement (if joining both networks)
- ☐ W-9 Form
- ☐ Direct Deposit Enrollment Form
- ☐ Specialty Documentation
- ☐ Other _____

Return all required information to:
Delta Dental of Virginia
Attn: Provider Relations
4818 Starkey Road
Roanoke, VA 24018

Use this form as your cover sheet if returning via fax.

We appreciate your decision to become a Delta Dental participating dentist. **Please assist us in expediting your membership by returning the required information promptly. Delta Dental of Virginia welcomes providers' suggestions on how we might improve our credentialing process.** Call 800.367.3531, ext. 3328 to speak with a Provider Relations Specialist.

DELTA DENTAL®

Delta Dental Networks

Since Delta Dental is the largest dental carrier in the country, many of your patients are likely already covered by Delta Dental. However, when your patient says, "*I am covered with Delta Dental*," it is important to ask them under which plan they participate (**this can be found in the upper right-hand corner of their ID card**). Delta Dental offers three networks: Delta Dental PPO™, Delta Dental Premier® and DeltaCare®, and a variety of plan types based on these networks. Determining in advance the plan your patients are covered under will help avoid any misunderstandings.

Delta Dental National Coverage

When you sign a Delta Dental of Virginia (DDVA) Participating Dentist Agreement, your participation is honored throughout the national Delta Dental system. Please keep in mind that if your patient is covered under a Delta Dental National Coverage plan, claims must be submitted to the appropriate Delta Dental member company for processing. You are still guaranteed direct payment and Virginia's plan allowances for these claims.

Delta Dental PPO™

Delta Dental PPO is our preferred provider network. This reduced fee-for-service program guarantees participating providers direct reimbursement. Employers actively encourage their employees to select Delta Dental's PPO network dentists because their out-of-pocket expenses may be lower.

Delta Dental Premier®

Delta Dental Premier is our traditional fee-for-service program. You are guaranteed direct reimbursement. Subscribers with Delta Dental Premier plans experience lower out-of-pocket costs when visiting a Delta Dental Premier participating provider.

DeltaCare®

DeltaCare is our managed care program, commonly referred to as a DHMO (Dental Health Maintenance Organization). Reimbursement is based on capitation and member copayments. **Members with DeltaCare *must* seek care from their selected DeltaCare dentist and any necessary specialty care referrals *must* be pre-authorized by DeltaCare.** If you are not the patient's selected DeltaCare dentist, please ask him/her to call DeltaCare at 800-862-0838 for participation information. Any services rendered by any dentist other than the patient's selected DeltaCare dentist becomes the patient's full financial responsibility.

DELTA DENTAL®

Individual Practitioner Profile

Complete this form in its entirety and **email it to ProviderRelations@deltadentalva.com** or fax it to 540.491.9709.

First Name _____ Middle Name _____ Last Name _____ Date of Birth ___/___/___

Other names used, if applicable _____

Degree _____ Gender (M/F) _____

Virginia Dental License Number _____

National Provider Identifier Number (NPI) _____

Office Email Address (please do not provide personal email addresses) _____

Number of years in practice _____

Professional schools attended _____ Year of graduation _____

Specialty program completed _____ Year of graduation _____

Name of specialty, if applicable _____

Are you a Board Certified specialist? ☐ Yes ☐ No **(Certificate is required — please attach a copy)**

Are you a Board Eligible specialist? ☐ Yes ☐ No **(Certificate is required — please attach a copy)**

Do you administer any level of anesthesia other than local anesthetic or nitrous oxide sedation?
☐ Yes ☐ No **(Anesthesia Permit is required — please attach a copy)**

CONTINUED ON NEXT PAGE

DELTA DENTAL®

Individual Practitioner Profile (Continued)

1. Have any malpractice claims or suits ever been filed against you? ☐ Yes ☐ No

2. Has your professional license in any state ever been denied, revoked, limited, suspended, put on probation or voluntarily relinquished? ☐ Yes ☐ No

3. Has your DEA permit ever been denied, revoked, limited, suspended, or voluntarily relinquished? ☐ Yes ☐ No

4. Have you ever been convicted of a criminal offense? ☐ Yes ☐ No

5. Have you ever been disciplined by a state board of dental examiners or a misconduct board? ☐ Yes ☐ No

6. Have you ever been subject to peer review action? ☐ Yes ☐ No

7. Have you ever had, or do you currently have, a chemical dependency or substance abuse condition? ☐ Yes ☐ No

8. Do you have any mental or physical condition that results in an inability to perform the essential functions of your profession, with or without accommodation? ☐ Yes ☐ No

9. Do you now or have you ever had any sanctions against you by the Office of Inspector General (OIG), Medicare and/or Medicaid? ☐ Yes ☐ No

10. Are you eligible for DEA or CDS certification? ☐ Yes ☐ No

11. If applicable, are your hospital privileges in good standing? ☐ Yes ☐ No

12. Does your office use infection control and barrier techniques according to CDC standards? ☐ Yes ☐ No

13. Does your office clean and heat sterilize high-speed, air-driven hand pieces and prophy angles after each patient? ☐ Yes ☐ No

14. Do you take initial medical/dental history with periodic updates? ☐ Yes ☐ No

15. Do you routinely use a dental or medical consent form for treatment? ☐ Yes ☐ No

If you answered "yes" to questions one through seven, please provide dates, circumstances and dispositions on a separate sheet of paper.

I hereby certify that the information provided and the answers to the questions on this profile are accurate and complete. I agree to immediately notify Delta Dental of Virginia in writing of any changes, including any changes to my professional liability insurance. I hereby give Delta Dental permission to request information from other entities regarding my professional credentials and qualifications. This release of information will not remain valid in the event the Participating Dentist Agreement is terminated.

_____ _____/_____/_____

Signature Date

Delta Dental of Virginia welcomes providers' suggestions on how we might improve our credentialing process. Call 800.367.3531, ext. 3328 to speak with a Provider Relations Specialist.

DELTA DENTAL®

Practitioner Five Year Work History*

Complete this form in its entirety.

Provider Name | Virginia Dental License Number

Practice/Employer Name

Employer Address

Date of employment, from _____/_____/_____ to _____/_____/_____

Practice/Employer Name

Employer Address

Date of employment, from _____/_____/_____ to _____/_____/_____

Practice/Employer Name

Employer Address

Date of employment, from _____/_____/_____ to _____/_____/_____

Practice/Employer Name

Employer Address

Date of employment, from _____/_____/_____ to _____/_____/_____

Practice/Employer Name

Employer Address

Date of employment, from _____/_____/_____ to _____/_____/_____

**Curriculum vitae, résumé, or other documents stating work history are welcomed in lieu of this sheet. If you are a recent graduate, simply state as such, as we are required to have a five year history for all providers.*

DELTA DENTAL®

National Provider Identifier (NPI) Form

Do you have your National Provider Identifier (NPI) yet?

The NPI is part of the required credentialing material necessary for participating Delta Dental of Virginia dentists. Complete and sign the form below. If your practice has multiple locations, copy this form and submit a separate form for each practice location/Tax ID number.
All forms should be faxed or returned to the fax number/address at the bottom of the page.

If you do not have an NPI, visit this website for your number: https://nppes.cms.hhs.gov/NPPES/Welcome.do

PRACTICE NPI					
Practice Name					
Correspondence Address			Physical Address		
City	State	Zip	City	State	Zip
Business Phone ( )	Fax Number ( )		Email		
Type II — NPI (Facility) Number			Tax ID Number		

INDIVIDUAL DENTIST NPIs		
I confirm that I have the NPI number stated below: Dentist Name:	Dentist Signature	
Type I — NPI (Individual) Number:	License Number	Date
I confirm that I have the NPI number stated below: Dentist Name:	Dentist Signature	
Type I — NPI (Individual) Number:	License Number	Date
I confirm that I have the NPI number stated below: Dentist Name:	Dentist Signature	
Type I — NPI (Individual) Number:	License Number	Date

▲ Delta Dental of Virginia, Attn: Provider Relations, 4818 Starkey Road, Roanoke, VA 24018 | 800.367.3531 ext. 3186 or Fax 540.774.7797

DELTA DENTAL®

Facility Profile Form

Please complete a facility profile for each office location. If you have more than one location, copy or print additional copies of this page. Complete this form in its entirety and **email it to ProviderRelations@deltadentalva.com** or fax it to 540.491.9709.

Facility Name (if any) _____

Tax ID Number (TIN) submitted on claims for this location _____

Business name (**as recorded with IRS on Form 941)** _____

Email Address _____

Physical Address _____

Payment Address (for checks only, if different from physical address) _____

_____

Correspondence Address (X-rays, provider updates and information other than checks)

_____

Telephone _____

Fax _____

Office Hours: Mon_____ Tues_____ Wed_____ Thurs_____ Fri_____ Sat_____ Sun_____

Are you accepting new patients? ☐ Yes ☐ No

Languages spoken (other than English) _____

Does this location have wheelchair access? ☐ Yes ☐ No

Public Transit accessibility? ☐ Yes ☐ No

Treats disabled adults? ☐ Yes ☐ No Treats disabled children? ☐ Yes ☐ No

Laboratory on site: ☐ Complete ☐ Limited

Number of Panoramic X-ray Units _____ Number of Periapical X-ray Units _____

Number of other X-ray Units _____ Number of Dental Assistants _____

Number of Hygienists _____ Number of Operatories _____

Are emergency services available 24 hours a day? ☐ Yes ☐ No

If yes, please check the type of service available: ☐ Home/Cell phone number ☐ Another local dentist

Are all permits and filings required by law and regulation current and valid (i.e., radiographic equipment)? ☐ Yes ☐ No

Are all staff members trained in CPR? ☐ Yes ☐ No

Do radiographic techniques meet accepted professional standards? ☐ Yes ☐ No

DELTA DENTAL®

Delta Dental PPO™ Participating Dentist Agreement

This Agreement ("Agreement") is between Dentist and Delta Dental of Virginia (DDVA). It is effective on the date that DDVA accepts it (as evidenced by DDVA's entry to that effect on the last page of the Agreement) and will remain in effect until either party terminates it in the manner provided for in the "Termination" section of the "Terms and Conditions" attachment. This Agreement applies specifically to DDVA's Delta Dental PPO program. With respect to Delta Dental PPO Enrollees, the terms and conditions in this Agreement control and supersede any contradictory provisions in the "Terms and Conditions" attachment.

DDVA's Payments and Other Delta Dental PPO Program Requirements

In our Delta Dental PPO program, we base our payments on Delta Dental PPO Allowances. You agree to accept Delta Dental PPO Allowances as payment in full for Covered Benefits that you provide to Delta Dental PPO Enrollees. This includes (without limitation) Covered Benefits provided after the Delta Dental PPO Enrollee reaches his or her Benefit Maximum and Covered Benefits subject to Patient Payment Amounts. DDVA reduces its payments by Patient Payment Amounts, as that term is defined in the "Terms and Conditions" attachment.

In this Agreement, the following terms have these meanings:

1. **Delta Dental PPO Allowance** means the lowest of (a) the fee that Dentist bills DDVA, or (b) the payment allowance that DDVA has established for the Dental Service that the Delta Dental PPO Enrollee receives. For the purposes of this Delta Dental PPO Agreement, when the term "Plan Allowance" is used in the "Terms and Conditions" attachment, it means the Delta Dental PPO Allowance.

2. **Enrollee** means an individual who is properly enrolled in, or otherwise eligible to receive Covered Benefits under, any Delta Dental Member Company's Delta Dental PPO contract with the Dental Delta group or the individual on the date on which the Dental Services are provided. Unless Dentist also participates in DDVA's DeltaCare network, DDVA's DeltaCare enrollees are considered Delta Dental PPO Enrollees for Specialist Dental Services. For the purposes of this Delta Dental PPO Agreement, when the term "Enrollee" is used in the "Terms and Conditions" attachment, it means a Delta Dental PPO Enrollee.

3. **Specialist Dental Services** mean Covered Benefits that are (a) provided under our DeltaCare enrollee's group or individual contract; (b) within specific, limited areas of dental specialization with respect to which we recognize Dentist as a specialist; and (c) Dentally Necessary (as that term is defined in the "Terms and Conditions" attachment to this Agreement). Specialist Dental Services include oral surgery, endodontics, periodontics, pediatric dentistry, and orthodontics.

Multiple Dentists and/or Dental Office Locations

If this Agreement applies to more than one dentist or dental office location, please copy and attach a separate signature sheet identifying the additional dentists, their license numbers, and/or the office locations where Dental Services will be provided.

Instructions for the Delta Dental PPO Dentist

To participate in Delta Dental's PPO network, Dentist must:

1. Sign and return to DDVA the signature page found on the next page of this Agreement.

2. Provide the information that we request for credentialing purposes; and

3. **Be accepted by DDVA (a copy of the signature page, with DDVA's representative's initials on it, will be returned to Dentist and should be kept in file with the remainder of this Agreement).**

DELTA DENTAL®

Delta Dental PPO™ — Participating Dentist Agreement Signature Page

Dentist, acting directly or by Dentist's authorized representative, has executed this Delta Dental PPO Agreement. Likewise, Delta Dental of Virginia, acting by its authorized representative, has accepted Dentist's application for participation in its Delta Dental PPO network and executed this Agreement.

Dentist

_____/_____/_____

Signature Date

_____

Printed Name

_____

Office Street Address

_____

City, State, Zip

_____

Phone Number

_____

Federal Tax ID or Social Security Number

_____

National Provider Identifier (NPI)

Delta Dental of Virginia

By:_____

To be completed by Delta dental of Virginia upon receipt of signature page:

Date Accepted by Delta Dental of Virginia:_____

Delta Dental of Virginia Representative Initials:_____

DELTA DENTAL®

Delta Dental Premier® Participating Dentist Agreement

This Agreement ("Agreement") is between Dentist and Delta Dental of Virginia (DDVA). It is effective on the date that DDVA accepts it (as evidenced by DDVA's entry to that effect on the last page of the Agreement) and will remain in effect until either party terminates it in the manner provided for in the "Termination" section of the "Terms and Conditions" attachment. This Agreement applies specifically to DDVA's Delta Dental Premier program. With respect to Enrollees, the terms and conditions in this Agreement control and supersede any contradictory provisions in the "Terms and Conditions" attachment.

DDVA's Payments and Other Delta Dental Premier Program Requirements

In our Delta Dental Premier network, we base our payments on Delta Dental Premier Allowances. You agree to accept our Delta Dental Premier Allowances as payment in full for Covered Benefits that you provide to our Delta Dental Premier Enrollees. This includes (without limitation) Covered Benefits provided after our Delta Dental Premier Enrollee reaches his or her Benefit Maximum and Covered Benefits subject to Patient Payment Amounts. DDVA reduces its payments by Patient Payment Amounts, as that term is defined in the "Terms and Conditions" attachment.

In this Agreement, the following terms have these meanings

1. **Delta Dental Premier Allowance** means lowest of (a) the fee that Dentist bills DDVA, or (b) the payment allowance that DDVA has established for the Dental Service that our Enrollee receives. For the purposes of this Delta Dental Premier Agreement, when the term Plan Allowance is used in the "Terms and Conditions" attachment, it means the Delta Dental Premier Allowance.

2. **Enrollee** means an individual who is properly enrolled in, or otherwise eligible to receive Covered Benefits under, any Delta Dental Member Company's Delta Dental Premier contract with the Dental Delta group or the individual on the date on which the Dental Services are provided. Unless Dentist also participates in one or more of our other network-based programs (Delta Dental PPO™ or DeltaCare®, for example), individuals enrolled in those programs are considered Enrollees for the purposes of this Delta Dental Premier Agreement.

Multiple Dentists and/or Dental Office Locations

If this Agreement applies to more than one dentist or dental office location, please copy and attach a separate signature sheet identifying the additional dentists, their license numbers, and/or the office locations where Dental Services will be provided.

Instructions for the Delta Dental Premier Dentist

To participate in Delta Dental's Premier network, Dentist must:

1. Sign and return to DDVA the signature page found on page 2 of this Agreement;

2. Provide the information that we request for credentialing purposes; and

3. **Be accepted by DDVA (a copy of the signature page, with DDVA's representative's initials on it, will be returned to Dentist and should be kept in file with the remainder of this Agreement).**

DELTA DENTAL®

Delta Dental Premier® — Participating Dentist Agreement Signature Page

Dentist, acting directly or by Dentist's authorized representative, has executed this Delta Dental Premier Agreement. Likewise, DDVA, acting by its authorized representative, has accepted Dentist's application for participation in its Delta Dental Premier network and executed this Agreement.

Dentist

_____/_____/_____

Signature Date

_____

Printed Name

_____

Office Street Address

_____

City, State, Zip

_____

Phone Number

_____

Federal Tax ID or Social Security Number

_____

National Provider Identifier (NPI)

Delta Dental of Virginia

By:_____

To be completed by Delta dental of Virginia upon receipt of signature page:

Date Accepted by Delta Dental of Virginia:_____

Delta Dental of Virginia Representative Initials:_____

DELTA DENTAL®

Participating Dentist Agreement Terms and Conditions

Section 1: Dentist's Obligations

1. **License, Certificates, and Authorizations.** You are a duly qualified and practicing dentist who holds a valid and unrestricted license to practice dentistry in the Commonwealth of Virginia and any other jurisdiction in which you provide Dental Services to Enrollees. You must maintain in good standing all licenses, specialty certificates, and other authorizations of any kind that are required to conduct your practice. You must promptly notify Delta Dental of Virginia (DDVA) of any investigation or action relating to any of these licenses, certificates or authorizations by any licensing board, certifying board or other organization.

2. **Credentialing and Re-Credentialing.** DDVA has established a credentialing program to ensure that Delta Dental Participating Dentists meet our standards for licensure, certification, providing Dental Services, and insurance. You must cooperate fully with our credentialing and re-credentialing program. We require credentialing documentation at the time that you apply to become a Delta Dental Participating Dentist. We also require you to update previously submitted information on an annual basis. The types of information we require include (without limitation) a current valid license; specialty certification (if applicable); practice or work history for the prior 5 years; current, adequate malpractice insurance coverage; and malpractice history for at least the prior 5 years. You must notify us at least 14 business days prior to any changes to your practice's name, address, phone number, or type of practice, and within 3 business days after you are notified in writing of any malpractice claim filed against you or your practice or any revocation, suspension or probationary action involving your license.

3. **Dentist/Patient Relationship.** The Agreement does not alter your professional relationship with your patients, including our Enrollees. We expect you to maintain dentist/patient relationships with our Enrollees. You are solely responsible to the Enrollee for your diagnosis, care, and treatment. Any decision whether to provide a service is your decision, and any decision whether to receive a Dental Service is the Enrollee's decision, regardless of whether the service is a Covered Benefit. You are an independent contractor, and neither we nor any group through which your patient is enrolled will have any control over your practice or the relationship between the patient and you. Our decision to include you as a Delta Dental Participating Dentist does not constitute an endorsement of your qualifications, fitness, or suitability to perform any service.

4. **Complying with Laws, Rules, Regulations, and Ordinances.** You will comply with all federal, state, and local laws, rules, regulations, and ordinances that pertain to your practice, including (without limitation) the United States Department of Health and Human Services' rules and regulations; OSHA rules and regulations; Center for Disease Control rules, regulations and guidelines; the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy rules; applicable requirements of the Department of Health, Board of Dentistry, and equivalent bodies in the state or other jurisdiction in which Dental Services are provided.

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DELTA DENTAL®

Participating Dentist Agreement Terms and Conditions (Continued)

5. **Standards of Care.** You must provide services to our Enrollees in accordance with the relevant professional standards for the type of practice, specialty or subspecialty, or region in which the Dental Services are provided to Enrollees. You will insure that the quality and availability of services provided to our Enrollees are not less than the quality and availability of services provided to all other patients to whom you provide services. Nothing in the Agreement limits, restricts or otherwise prohibits you from fully disclosing all dental treatment options to our Enrollees, whether or not the treatment options are Covered Benefits, if you determine that these options are in the Enrollees' best interests.

The following are never Covered Benefits: Dental Services that are (a) demonstrably below generally accepted standards of dental practice; (b) clinically inappropriate, in terms of type, frequency, extent, site, or duration; or (c) generally considered ineffective for the diagnosis or treatment of the patient's injury or disease. You may not bill or otherwise collect from our Enrollee any fee for Dental Services of this type, and you will promptly refund to our Enrollee any Patient Payment Amounts that have been collected for these services.

6. **Claims and Payments.**

a. **Filing Claims.** Except as provided herein, you must submit claims to us for Dental Services that you provide to our Enrollees within 12 months after (i) the date on which the service is completed or (ii) the last day on which the last service in a series of related services is completed (if a series is required). Completion dates include the seating date for crowns and bridges, delivery of partial or complete dentures, and final fill for root canal treatment. There is a different timely filing period for orthodontic services. You must file claims for orthodontic services after banding or initial placement of an orthodontic device. DDVA then makes periodic payments for orthodontic services over the entire course of orthodontic treatment up to the Benefit Maximum under the Enrollee's Dental Services plan. For all Dental Services, you must submit claims on standard claim forms or by another means of reasonable, timely, and accurate claims submission (including electronic submission) to which DDVA has agreed in advance. You must identify Dental Services provided to our Enrollees using dental nomenclature from the most recent edition of the publication Current Dental Terminology ("CDT"). Amounts that you bill us will not exceed amounts that you typically charge the general public for Dental Services. If you discount your usual fees for Dental Services, whether as a professional courtesy to the patient or as part of a commercial arrangement that provides for discounted fees, you agree to bill us no more than the discounted fee for the service that you provide to our Enrollee. Claims for Dental Services should be submitted directly to the Enrollee's Delta Dental Member Company if that company is other than DDVA.

You agree to bill us for Dental Services using the CDT procedure codes that most accurately describe the Dental Services that you provide to our Enrollees. We base our payment on our determination of the most accurate CDT procedure code. You must not bill for Dental Services using multiple CDT procedure codes if there is a single, more comprehensive CDT code for the services. We base our payment on the allowance for the more comprehensive code, not on the allowances for the underlying component codes. For information regarding these and other uniform claims processing

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policies and procedures, please visit our website at **DeltaDentalVA.com** or request a written copy from DDVA's Dental Director at the address provided in the "Notices" paragraph of this document.

b. **Fee Adjustments.** We recognize that there are special circumstances that may make some Enrollees' dental treatment more complicated than other patients' treatment. In these circumstances, you may request that we consider an adjustment to the Plan Allowance. Your request must include a written description of the special circumstances and reasons for the adjustment. You may make the request in a separate letter attached to the claim form or as part of a request for reconsideration. Timely filing rules described in Paragraph 6.a. in this section also apply to fee adjustment requests.

c. **Optional Treatment.** After consulting with you, an Enrollee may select a more expensive Dental Service than the one that we determine is Dentally Necessary for the diagnosis or treatment of the Enrollee's condition ("Optional Treatment"). We will only pay the amount that we would have paid for the less expensive Covered Benefit. In most cases, our payment for Optional Treatment will not exceed the amount that we customarily pay to restore the patient's tooth or dental arch to its proper contour and function. Our Enrollee is responsible for the difference between the Plan Allowance for Optional Treatment and our payment allowance for the less expensive Covered Benefit.

d. **Enrollee's Payments.** Except as otherwise specifically provided in this Agreement, you will not bill or otherwise collect from our Enrollees the differences between your charges for Dental Services and the Plan Allowances for these services. In the special circumstances described in paragraph 6.c. and 6.d. of this section, you will not bill or otherwise collect from our Enrollees the differences between your charges for Dental Services and the adjusted Plan Allowances. You agree not to waive Patient Payment Amounts, and you will make reasonable efforts to collect Patient Payment Amounts. You may request these amounts in advance or at the time of treatment. You will not bill us or otherwise collect from our Enrollee any amount for any service that is not a Dental Service, including (without limitation) a charge to complete a claim form, copy records or respond to our request for additional information. You will not charge our Enrollee, either in advance or otherwise, for any part of your bill that is payable by a Delta Dental Member Company, including DDVA.

7. **Records.** You must maintain accurate and complete patient treatment, financial and accounting records in accordance with generally accepted dental office management practices. Without limiting the scope of the preceding requirement, you must retain these records during the term of the Agreement and for at least 6 years after its termination. You must cooperate fully in our post-treatment claims review programs. You agree to furnish, without charge, copies of our Enrollees' dental records, including x-rays and written or electronic patient records that we reasonably request, for a period of up to 6 years after (a) the date on which the service is completed or (b) the last day on which the last service in a series of related services is completed (if a series is required). You must provide us with access, during your regular business hours and upon reasonable advance notice, to your insurance policies and other records that relate to Dental Services provided to our Enrollees and charges to and payments from our Enrollees in sufficient quantity (as reasonably requested by DDVA) to verify compliance with the Agreement. Your obligation to keep and provide these records

CONTINUED ON NEXT PAGE

to us will not terminate upon the termination of the Agreement, regardless of the reason for termination.

8. **Uniform Policies and Procedures.** You agree to abide by uniform policies and procedures, of which you are advised in writing in advance, that we have adopted with respect to Dental Services furnished to our Enrollees. These include our billing procedures, utilization review standards, and quality assurance programs for Delta Dental Participating Dentists. In addition, you must cooperate fully with utilization review and quality assurance programs that are implemented for our Enrollees' benefit. Upon reasonable advance request, you may be asked to complete and provide us with periodic quality assurance surveys.

9. **Confidential and Proprietary Information.** You will maintain the confidentiality of Enrollee records in accordance with applicable federal and state laws and regulations and DDVA's uniform policies and procedures. In addition, our payment schedules, groups' names and addresses, provider manual and other descriptions of utilization and quality review programs, internal operations, and reimbursement methodologies, which are not otherwise available to the public, are our confidential and proprietary documents. Except as otherwise required by law, you will maintain the confidentiality of these documents and, at our request, return them to us after termination of the Agreement.

10. **Insurance.** You will, at your cost and expense, procure and maintain policies of general liability, malpractice and other insurance necessary to insure against liability, claims or damages arising by reason of personal injuries or death to our Enrollees, occasioned directly or indirectly by your acts or omissions ("insurance coverage"). The amount of this insurance coverage must be customary and reasonable for your type of practice, specialty or subspecialty, and the prevailing practices in the area in which you practice. Upon request, you must provide us with a certificate of insurance or other documentation which confirms that insurance coverage is in force. You must notify us immediately of the cancellation of insurance coverage. If, during the period in which you provide Dental Services to our Enrollees, you maintain professional liability insurance on a "claims incurred" basis, you must maintain in force sufficient "tail" insurance to assure full and continuing coverage through the policy's extended reporting period.

11. **Non-discrimination.** You may not discriminate in the treatment or quality of services provided to Enrollees on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, Vietnam-era veteran's status, ancestry, health status or need for health services of these Enrollees and without regard to source of payments made for health services rendered to these Enrollees. You will make your professional services accessible to Enrollees during the same hours and with the same intensity as you make those services available to non-Enrollees.

You agree to comply with all applicable federal and state laws relating to non-discrimination and equal employment opportunity, including the Civil Rights Act of 1964, the American's with Disabilities Act, regulations issued pursuant to that Act and provision of Executive Order 11246 dated September 26, 1965. You also agree to provide physical and program accessibility of dental services to persons with physical and sensory disabilities pursuant to Section 504 of the Rehabilitation Act of 1973,

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DELTA DENTAL®

Participating Dentist Agreement Terms and Conditions (Continued)

as amended (29 U.S.C. 794), all requirements imposed by any applicable DHFS regulations (45 C.F.R. Part 84) of HCFA regulation (42 C.F.R. Parts 417 and 434) and all applicable guidelines and interpretations issued pursuant thereto.

12. **Hold Harmless.** You agree that in no event, including but not limited to non-payment by DDVA or a carrier that has embedded a DDVA dental services plan as part of its qualified medical plan (the latter hereinafter "Plan"), insolvency of DDVA or Plan, or breach of this Agreement, will you bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Enrollees or persons other than DDVA and / or Plan for Covered Services provided pursuant to this Agreement, provided however, that this provision shall not prohibit collection of applicable Patient Payment Amounts billed in accordance with this Agreement and the terms of the applicable Enrollee contracts or policies.

You agree that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of Enrollees; and that (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between DDVA or Plan and you and the Enrollee or persons acting on the Enrollee's behalf.

Section II: DDVA's Obligations

1. **Timely Filing.** Except as otherwise provided in the Agreement, we will pay a claim for Covered Benefits if it is filed with us within 12 months after (a) the date on which the service is completed or

(b) the last day on which the last service in a series of related services is completed (if a series is required). There is a different timely filing period for orthodontic services. You must file claims for orthodontic services after banding or initial placement of an orthodontic device. After the claim is filed, we make periodic payments for orthodontic services over the entire course of orthodontic treatment up to the Benefit Maximum under the Enrollee's Dental Services plan. For all Dental Services (including orthodontic services), we will only consider an adjustment to a previously submitted claim if it is resubmitted within 12 months after the original claim is processed. We will not pay a claim or make an adjustment submitted after the end of these timely filing periods.

[Explanatory Note: VA Code § 38.2-3407.15 requires that the following paragraphs 2 through 12 be part of the Agreement. Paragraphs 2 through 12 apply to each "claim" (as defined in this section) made under Dental Services plans that DDVA insures directly. The terms and conditions of paragraphs 2 through 12 do not apply to services under any plan that an employer or other group self-insures. They do not apply to any other Delta Dental Member Company's plan. DDVA's uniform policies and procedures for Delta Dental Participating Dentists and the terms and conditions of our Enrollees' dental plans, to the extent these terms and conditions may differ, apply to and supersede Paragraphs 2 through 12 for all plans to which VA Code § 38.2-3407.15 does not apply.

2. **Claims Payments.** DDVA will pay any claim for Covered Benefits submitted by you or on your behalf within 40 days after receipt of the claim except where DDVA's obligation to pay the claim is

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not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. DDVA has determined that the claim is not a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

3. **DDVA's Claims Records.** DDVA will maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim will be entitled to inspect this record and to rely on the record or on any other admissible evidence as proof of the fact of receipt of the claim, including (without limitation) electronic or facsimile confirmation of receipt of the claim.

4. **Requests for Additional Claims Information.** DDVA will, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that DDVA reasonably believes will be required to process and pay the claim or to determine whether the claim is a clean claim. Upon receipt of the additional information requested under this paragraph necessary to make the original claim a clean claim, DDVA will make the payment of the claim in compliance with this section. DDVA will not refuse to pay a claim for Dental Services rendered pursuant to the Agreement, which are Covered Benefits, if DDVA fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claim. However, nothing herein will preclude DDVA from imposing a retroactive denial of payment of such a claim if the time that has elapsed since the date of the payment of the original claim does not exceed 12 months. Nothing in this section will require DDVA to pay a claim that is not a clean claim or to pay for Dental Services that are not Covered Benefits.

5. **Interest.** Any interest owing or accruing on a claim under Section 38.2-3407.1 or Section 38.2-4306.1 in Title 38.2 of the Code of Virginia, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter. [Explanatory Note: For payments made on or after January 1, 2019 for insured or "risk" claims only, no dental or optometric services plan, including DDVA, is required to pay interest computed under VA Code Section 38.2-3407.1 if the total interest is less than $5.00. The Virginia claims "interest" statute does not apply to ASO claims].

6. **Access to Pre-Determination Review, Authorization and DDVA's Policies and Procedures.**

a. DDVA has established and implemented reasonable policies to permit you (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the Dental Services to be provided are Dentally Necessary and Covered Benefits; and (ii) to determine DDVA's requirements that apply to you or the type of Dental Services that you have contracted

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to provide under the Agreement for (a) pre-determination or authorization of coverage decisions; (b) retroactive reconsideration of a pre-determination or authorization of coverage decision or retroactive denial of a previously paid claim; (c) provider-specific payment and reimbursement methodology, coding levels and methodology, down-coding and bundling of claims; and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the Agreement, including determining whether a claim is a clean claim.

b. Under certain circumstances, DDVA may notify you in writing that you must submit some or all required Dental Services to DDVA for prior authorization. In the event you fail to submit a Covered Benefit in accordance with DDVA's written notification, DDVA may deny, in whole or in part, claims for Covered Benefits submitted without this authorization. You may not charge to our Enrollee for any such denied amount.

c. DDVA will make available to you, within 10 business days of receipt of your request, copies of or reasonable electronic access (if available) to all such policies that apply to you or the particular Dental Services that you have identified. In the event the provision of the entire policy would violate any applicable copyright law, DDVA may instead comply with this paragraph by timely delivering to you a clear explanation of the policy as it applies to you or the particular Dental Services that you have identified.

7. **Pre-Determination of Claims.** DDVA will pay a claim if it has previously determined that the Enrollee's Dental Service is a Covered Benefit or has advised you or the Enrollee in advance of the provision of Dental Services that the Dental Services are Dentally Necessary and Covered Benefits, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

b. DDVA's refusal is because (i) another payer is responsible for the payment; (ii) we have already paid the claim for Dental Services; (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information that you provided to DDVA, the Enrollee, or another person not related to DDVA; or (iv) the person receiving the Dental Services was not eligible to receive them on the date of service and DDVA did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.

8. **Retroactive Denials; Limitations.** DDVA will not impose any retroactive denial of a previously paid claim unless it has provided the reason for the retroactive denial and (a) the original claim was submitted fraudulently; (b) the original claim payment was incorrect because the Dental Services identified on the claim have already been paid or you did not deliver the Dental Services identified on the claim; or (c) the time that has elapsed since the date of the payment of the original challenged claim does not exceed 12 months. DDVA will notify you at least 30 days in advance of any retroactive denial of a previously paid claim.

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DELTA DENTAL®

Participating Dentist Agreement Terms and Conditions (Continued)

9. **Retroactive Denials; Identification.** The provisions of the immediately preceding paragraph notwithstanding, DDVA will not impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless DDVA specifies in writing the specific claim or claims for which it has imposed the retroactive denial or the recovery or refund is sought. DDVA will include, in the written communication, an explanation why the claim is being retroactively adjusted.

10. **Access to Reimbursement and Other Information.** DDVA's reimbursement policies that apply to you and DDVA's statement as to the manner in which claims will be calculated and paid, which apply to you, are provided as part of the Agreement. You have been, or will be, furnished with all material addenda, schedules and exhibits thereto and any policies (including those referred to in paragraph 6 of this section) that apply to you or the range of Dental Services that you are reasonably expected to provide under the Agreement.

11. **Copyright Laws.** In the event that DDVA's providing a policy as required under paragraph 6 or 10 of this section would violate any applicable copyright laws, DDVA may instead comply with this section by providing a clear, written explanation of the policy as it applies to you.

12. **Definitions for this Section II:** as used in paragraphs 2 through 12 of this section only, the following terms have these meanings:

a. **Claim** is any bill, claim, or proof of loss made by or on behalf of the Enrollee or you to DDVA (or DDVA's intermediary, administrator or designated representative) under the Agreement for payment for Dental Services under any program of Dental Services that DDVA insures; however, a "claim" shall not include a request for payment of a capitation fee or withhold.

b. **Clean claim** means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which DDVA has failed to timely notify the person submitting the claim of any such defect or impropriety in accordance with this section.

c. **Retroactive denial** of a previously paid claim or retroactive denial of payment means any attempt by DDVA retroactively to collect payments already made to you with respect to a claim by reducing other payments currently owed to you, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to you.

Section III: General Provisions

1. **Notices.** Any notice that DDVA sends to you under the Agreement will be sent to your address of record on file with DDVA. Any notice that you send to DDVA under the Agreement must be sent to:

Dental Director, Delta Dental of Virginia
4818 Starkey Road
Roanoke, Virginia 24018

Any notice of termination of the Agreement by either party must be sent to the other party by certified mail, return receipt requested, with postage prepaid.

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DELTA DENTAL®

Participating Dentist Agreement Terms and Conditions (Continued)

2. **Changes to the Agreement.** DDVA may amend the Agreement at any time by providing you with a written copy of the amendment. No amendment to the Agreement or any addendum, schedule, exhibit or policy thereto (or new addendum, schedule, exhibit or policy) that applies to you (or the range of services that you are reasonably expected to provide to our Enrollees) will be effective as to you, unless (a) you have been notified in writing of the applicable portion of the proposed amendment (or the proposed new addendum, schedule, exhibit or policy) at least 60 calendar days before its effective date and (b) you have failed to notify DDVA within 30 calendar days after receipt of the document(s) that you will terminate the Agreement at the earliest date thereafter permitted under the Agreement. The preceding provisions in this paragraph notwithstanding, this Agreement may be amended immediately upon written notice from DDVA so that we may comply with applicable laws, regulations or other government directives.

3. **Assignment.** Neither party may assign, subcontract, delegate or transfer its duties or obligations under the Agreement unless the other party expressly consents in writing in advance. Any attempted assignment, subcontract, delegation or transfer not in accordance with the terms of this paragraph is void. There are two exceptions: (a) DDVA may assign its duties or obligations to any entity that controls, is controlled by, or is under common control with DDVA now or in the future; and (b) DDVA may assign its duties and obligations to any entity that succeeds to DDVA's business by merger or other reorganization.

4. **Third Party Beneficiaries.** This Agreement is entered into by and among the parties hereto solely for their benefit. The parties have not created or established any third party beneficiary status or rights in any person or entity that is not a party to the Agreement including, without limitation, any other dentist not subject to the Agreement, other provider, subcontractor or third party. Any individual or entity that is not a party to the Agreement does not have the right to enforce any term or condition of the Agreement or enjoy any benefit of the Agreement.

5. **Non-Exclusive Agreement.** The Agreement is not an exclusive agreement. In other words, we may enter into similar agreements with other dentists and dental practices, and you are not expected to limit your practice to our Enrollees.

6. **Use of Name.** By entering into the Agreement, you authorize us to include your name, office address, telephone number, and type of practice in our listing of providers participating in our Dental Services network(s). We may distribute these listings to (without limitation) Enrollees, groups, other Delta Dental Member Companies, participating dentists, and regulatory agencies. You authorize us to release other identifying information about you that is required by federal or state law or by covered groups subject to applicable confidentiality provisions.

7. **Force Majeure.** Neither party is in violation of the Agreement for failure to comply with the Agreement's terms and conditions if that failure is due to matters beyond the non-complying party's reasonable control (such as acts of God, insurrection, strike, fire, or power outages), provided that the failure is not caused in material part by the non-complying party.

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DELTA DENTAL®

Participating Dentist Agreement Terms and Conditions (Continued)

8. **Waiver.** Either party's waiver of a breach of the Agreement will not be construed to be a waiver of any subsequent breach. Failure to exercise any right or remedy under the Agreement is not a waiver of the right or remedy. All remedies provided in the Agreement are cumulative.

9. **Governing Law.** The validity, enforceability, construction, and interpretation of the Agreement or any clause of the Agreement shall be governed by the applicable laws of the Commonwealth of Virginia in effect at the time of such construction or enforcement, except the Commonwealth's choice of laws requirements and federal laws that expressly preempt state laws.

10. **Invalid or Unenforceable Provisions.** If any provision of the Agreement is held to be illegal, invalid, or unenforceable, that provision is fully severable. If the severed provision is not material to the Agreement's overall purpose and operation, the Agreement will be construed and enforced as if the illegal, invalid or unenforceable provision had never been part of the Agreement. In this case, the remaining provisions will remain in full force and effect. If the severed provision is material to the Agreement's overall purpose and operation, the Agreement will automatically terminate upon its severance.

11. **Liability for Acts and Omissions.** Except as otherwise provided herein, each party (the "responsible party") is solely responsible for all direct, compensatory, punitive, indirect, consequential, non-economic or other damages of every type, which are assessed against and/or incurred by the responsible party, whether by verdict, settlement or otherwise, and which arise out of or result from: (a) the acts or omissions of the responsible party and/or the responsible party's employees or subcontractors (provided that under no circumstances will we be liable for a dentist's care for, advice to, or treatment of any Enrollee); (b) the responsible party's breach of any duty or obligation arising under the Agreement; or (c) any violation by the responsible party of any federal, state or local statute, regulation, ordinance, ruling and/or judicial or administrative order that applies to the responsible party or its employees or subcontractors.

12. **Resolving Disputes.**

a. Arbitration and Resolution. In the event of a dispute under the Agreement, which cannot be satisfactorily resolved between the parties' designated representatives, the dispute must be resolved by arbitration in accordance with the rules and regulations of the American Arbitration Association, as then in effect. Either party may initiate arbitration by making a written demand for arbitration on the other party within 60 days of the time the dispute arises. Within 30 days of this demand (or as soon thereafter as reasonably practical), the parties shall each designate an arbitrator and give written notice of such designation to the other party. Within 30 days after receipt of such notices (or as soon thereafter as reasonably practical), the two designated arbitrators shall select a third arbitrator and give notice of the selection to both parties hereto. If the dispute involves Dental Necessity or requires professional dental judgment, at least two of the arbitrators will be dentists who have experience with or dental expertise in the subject matter at issue. The three arbitrators shall hold a hearing and decide the matter within 90 days (or as soon thereafter as reasonably practical). The result of the arbitration shall be final and binding upon the parties to the same extent

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that the parties would have been bound by a legally enforceable judgment with respect to the matter in dispute. Each party will bear the expenses of its designated arbitrator, and the parties shall share equally the expenses of the third arbitrator.

b. **Exceptions.** Notwithstanding the foregoing provisions of this "Resolving Disputes" paragraph, the following matters are not subject to arbitration or the operation of this arbitration clause: (a) any suit or action, including any counterclaim, cross-claim or third-party claim, in any suit against you pursuant to the Agreement or DDVA, for indemnity or contribution arising out of the services provided under the Agreement; and (b) "for cause" termination of your participation as a Delta Dental Participating Dentist. The mandatory process for resolving disputes that result from "for cause" termination of a dentist's participation as a Delta Dental Participating Dentist are in the document entitled "Provider Appeal of Termination," which is attached to and made a part of the Agreement.

c. **Limitations on Actions.** Each party must provide at least 30 days prior notice to the other party before initiating arbitration or bringing any other legal action against the other party, its officers, employees, agents or representatives. This notice must specify the nature of the dispute and/or causes of action. No arbitration proceeding or other legal action may be brought more than one year after the date on which the causes of action first arose. Damages available as a result of arbitration or any other legal action under the Agreement are limited to the claimant's actual damages that result from the claims asserted. In no event are punitive, indirect, consequential or non-economic damages or damages for emotional distress or mental anguish available under the Agreement.

13. **Termination.**

a. **Method of Termination.** Except as outlined in this section, either party may terminate the Agreement "for cause" if the party seeking termination (i) provides the other party with written notice specifying the nature of the defect giving rise to termination and (ii) affords the other party at least 30 days within which to cure the defect. If, in the judgment of the party seeking termination, the defect cannot be cured within this 30-day period, the effective date of termination will be the date specified in the notice. In the event your professional license is surrendered, forfeited, or revoked or if you are placed on suspension or fail to renew your professional license within the timeframes required, the Agreement will terminate upon the date of such event. Either party may terminate the Agreement "without cause" upon at least 90 days prior written notice to the other party.

b. **Notice of Termination.** You must notify in writing all of our Enrollees who are your patients that you are no longer a Delta Dental Participating Dentist. Each of these Enrollees must receive the notice at least 30 days before the Enrollee's next visit after the effective date of termination. If, during the first year following termination of the Agreement, you fail to notify our Enrollee in the manner provided for in this paragraph, you are bound by the terms and conditions of the Agreement for Dental Services provided prior to the Enrollee's receipt of the required notice, including (without limitation) the prohibition against balance-billing the differences between (i) your charges and (ii) the Plan Allowances for the services provided.

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DELTA DENTAL®

Participating Dentist Agreement Terms and Conditions (Continued)

c. **Obligations after Termination.** Termination of the Agreement in whole, or as it relates to any DDVA program in which you participate, shall have no effect upon the rights or obligations of the parties arising out of any transactions occurring prior to the effective date of termination and the continuing obligations after termination provided for in the Agreement. Termination will not change your obligations under the Agreement for any Enrollee who has begun a course of dental treatment with you. Our Enrollee will continue to receive the benefits of his or her individual or group Delta Dental contract, including (without limitation) your commitment to accept our Plan Allowances as payment in full for Covered Benefits, through the end of his or her course of dental treatment.

13. **Appeal of Termination.** Any other provision of the Agreement to the contrary notwithstanding, if your participation as a Delta Dental Participating Dentist is terminated "for cause," you must use DDVA's mandatory appeal process before you take any further legal or administrative action. The document entitled "Provider Appeal of Termination" describes this mandatory appeal process. DDVA will provide more specific information about the appeal process with the notice of termination or upon request.

14. **Binding Effect.** The Agreement shall be binding upon and inure to the benefit of the parties to the Agreement and their respective heirs, successors and permitted assigns.

15. **Entire Agreement.** This Agreement includes and incorporates by reference all amendments to this Agreement, the separate signature page document, the "Provider Appeal of Termination" attachment to the Agreement, and DDVA's provider manual. It contains all the terms and conditions to which the parties have agreed with respect to Enrollees and supersedes any and all other agreements, oral or written, regarding Enrollees or the subject matter of this Agreement.

Section IV: Definitions

The following terms used anywhere in the Agreement have these meanings:

1. **Benefit Maximum** is the maximum dollar amount that we will pay for Covered Benefits during the benefit period specified in the Enrollee's Dental Services plan (a calendar year, for example).

2. **Coinsurance** is a fixed percentage of the Plan Allowance that our Enrollee must pay for a Covered Benefit. Coinsurance reduces the amount that we would otherwise pay for a Covered Benefit.

3. **Copayment** means a fixed dollar amount of the Plan Allowance that our Enrollee must pay for a Covered Benefit. A Copayment reduces the amount that we would otherwise pay for a Covered Benefit.

4. **Covered Benefits** mean one or more Dental Services that are covered under the Delta Dental Member Company's contract with the Enrollee's group or the Enrollee on the date on which the Dental Services are provided.

5. **DDVA** means Delta Dental of Virginia.

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DELTA DENTAL®

Participating Dentist Agreement Terms and Conditions (Continued)

6. **Deductible** is a fixed dollar amount that an Enrollee must pay for Covered Benefits before we begin to pay for Covered Benefits. A Deductible reduces the amount that we would otherwise pay for Covered Benefits.

7. **Delta Dental Member Company** means any company licensed to use the Delta Dental name and service mark (including DDVA) which has entered into a "DeltaUSA Interplan Participating Agreement" or a successor agreement that is in effect on the date on which the Dental Services are provided.

8. **Delta Dental Participating Dentist** means a dentist who has entered into one or more network-specific Participating Dentist Agreements with DDVA, which is in effect on the date on which the Dental Service is provided.

9. **Dental Services** mean care and procedures provided for the diagnosis, treatment of dental disease or injury, and services provided to promote overall oral health and well-being. Not all Dental Services are Covered Benefits.

10. **Dentally-Necessary or Dental Necessity** means those Dental Services that a dentist or other qualified dental professional, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating a dental injury, disease or its symptoms. Dentally Necessary services must be (a) in accordance with generally accepted standards of dental practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's injury or disease; (c) not primarily performed for the convenience of the patient, the dentist, other dental professional or health care provider; and (d) not more costly than an alternative service at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's injury or disease. "Dental Necessity" includes (without limitation) treatments involving dental structures and pathology which, while rarely "medically" necessary, are essential to resolve the condition of dental disease or pathosis.

A "medically" necessary situation as it relates to dental therapies is one in which failure to provide the Dental Services would result in deleterious effects to the patient's overall health status or are necessary to sustain the patient's life.

For these purposes, "generally accepted standards of dental practice" mean standards that are credible, scientific, evidence-based and published in peer-reviewed dental literature generally recognized by the relevant dental community, or otherwise consistent with the applicable dental specialty association's recommendations and the views of practitioners in the relevant clinical areas.

11. **Dentist**, you, or your means the individual dentist, partnership, corporation, limited liability company or similar entity on whose behalf the Agreement is signed and which DDVA has accepted as a Delta Dental Participating Dentist. Whenever the term "you" or "your" is used in the Agreement, it means the dentist and any other dental care professional, employee or subcontractor who provides Dental Services to our Enrollees under the dentist's supervision.

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12. **Enrollee** means an individual who is properly enrolled in or otherwise eligible to receive Covered Benefits under any Delta Dental Member Company's contract with the individual's group or the individual on the date on which the Dental Services are provided.

13. **Patient Payment Amounts** mean Coinsurance, Copayments, Deductibles, and other charges for Covered Benefits for which our Enrollees are responsible under their group or individual Dental Services contracts with Delta Dental Member Companies.

14. **Plan Allowance** means the maximum amount on which the Delta Dental Member Company's payment is based under the network-specific agreement with respect to which you are a Delta Dental Participating Dentist.

15. **We, us, or our** means DDVA or another Delta Dental Member Company if the context requires reference to another Delta Dental Member Company (for example, "our Enrollee").

DELTA DENTAL®

Delta Dental of Virginia
Provider Appeal of Termination

Policy

In an effort to provide Delta Dental of Virginia's (DDVA's) Delta Dental Participating Dentists with a means to resolve grievances that arise from "for cause" termination of participation in DDVA's provider networks, DDVA provides the dentist whose participation in a DDVA provider network has been terminated with a means to appeal the decision and obtain a reversal (if appropriate).

This process is designed to give the dentist a better understanding of the circumstances giving rise to termination, an opportunity to be heard on the issue(s) that resulted in termination, and obtain a reversal (if appropriate). This process is a firm prerequisite to legal action, meaning that the Participating Dentist must avail himself or herself of this process before bringing any action or seeking any redress in the courts.

Provider Appeal Panel

For the purposes of this review, the provider appeal panel will consist of three dentists (the "Provider Appeal Panel"). Two of these dentists will be DDVA Participating Dentists who are not DDVA employees and have no financial interest in the outcome of the appeal. These dentists may receive compensation for their participation on the Provider Appeal Panel. The third dentist will be a DDVA employee. The three dentists may, by majority vote, elect the Provider Appeal Panel's chairperson.

The Provider Appeal Panel will have authority to make a binding determination about the validity of DDVA's "for cause" termination of participation in a DDVA provider network. The result will bind the parties to the same extent they would be bound a judgment in a court proceeding.

Appeal Process

A dentist, whose participation in one or more of DDVA's provider networks is terminated by DDVA, may submit a written request to appeal the termination decision within 30 days after the date of DDVA's termination letter. The appeal letter should include sufficient detail for the Provider Appeal Panel to evaluate the merits of the appeal. All documentation that supports a reversal should be included.

If a hearing with the Provider Appeal Panel is requested, DDVA's Provider Relations Department will schedule the hearing within 60 days after receipt of the appealing dentist's written request (or as soon thereafter as reasonably practical).

The hearing by the Provider Appeal Panel will be conducted informally. Rules of evidence that would govern a judicial-type hearing will not apply. Neither DDVA nor the appealing provider must be represented by an attorney, although neither party's attorney will be excluded from the hearing.

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DELTA DENTAL®

Delta Dental of Virginia Provider Appeal of Termination (Continued)

Prior to the hearing, each party must advise the other party of the names, identity, and anticipated testimony of all persons who will make arguments or present testimony to the Provider Appeal Panel. The members of the panel may, by majority vote, exclude any individual or group who is not attending the hearing to argue the merits or present testimony or whose presence is not deemed necessary by the panel for a full and proper evaluation of the appeal.

At the beginning of the review hearing, a Notary Public or other officer authorized to administer oaths shall swear all witnesses. Minutes of the hearing will be kept by an individual designated to do so by DDVA's Dental Director.

DDVA's Dental Director or his designee will provide an opening statement that includes the reason(s) why the termination decision was made and the contractual performance, regulatory compliance or quality of care issues that gave rise to the termination decision.

The appealing dentist may then make an opening statement in person or through counsel.

Witnesses will be called by the chairperson of the Provider Appeal Panel (sworn affidavits may be substituted in lieu of live witnesses). Unless one or both of the parties are represented by counsel, only the Provider Appeal Panel members may query the witnesses. The chairperson of the Provider Appeal Panel may set time limits for the length of the hearing, presentation of testimony, examination of witnesses, and arguments on the merits, and will decide all other procedural matters.

Any documents that bear upon the issues may be submitted to the panel by the appealing dentist or DDVA's Dental Director. DDVA's Dental Director and the appealing dentist may make a closing statement in person and through counsel.

After the hearing is concluded, the Provider Appeal Panel members will adjourn to evaluate the merits of the appeal. All persons who are not members of the Provider Appeal Panel will be excluded from these deliberations.

The Provider Appeal Panel will furnish the appealing dentist, directly or through counsel, a written decision on the outcome of the appeal within 14 calendar days after the hearing date. The Provider Appeal Panel may extend the time within which to respond by notifying the appealing dentist, directly or through counsel, of the anticipated date of the panel's response. If, in the Provider Appeal Panel's sole judgment, a second hearing is required, the chairperson of the Provider Appeal Panel or his or her designee will so notify the dentist. These same rules will apply to any second hearing.

Each party will bear its own expenses for any appeal.

The result of the Provider Review Panel's decision shall be final and binding upon the parties to the same extent that the parties would have been bound by a legally enforceable judgment with respect to the matter in dispute. The submitted documents and testimony will remain confidential unless subpoenaed in a subsequent administrative or judicial proceeding or DDVA determines, on advice of counsel, that applicable federal or state law or regulations compel their disclosure.

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

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. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

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

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note. *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov/online/ss-5.pdf*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses/* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Direct Deposit Enrollment Form

Complete this form in its entirety and **email it to ProviderRelations@deltadentalva.com** or fax it to 540.491.9709.

Reason for submission:
☐ **New EFT/ERA authorization**: complete A, B, C, D and E ☐ **Cancel EFT/ERA**: complete A and G
☐ **Changes to an existing EFT/ERA authorization**: complete A, B, C, E, F and H

A. Dentist Information

Provider's Complete Legal Name	Practice Name		
Address	City	State	Zip
Phone ( )	Fax ( )		
Name of Office Contact	Provider's Email Address		
Provider National Provider Identifier (NPI), if applicable	Assigning Authority		
Provider Tax Identification Number (TIN)	Provider License Number	Issuing State	

Please indicate which locations you would like to have this Direct Deposit Form include:
☐ Only this location ☐ All locations ☐ I will attach the address of the locations

B. Banking/Financial Institution Information (please print or type)

Financial Institution's Name	Account Number	Routing Number	
Address	City	State	Zip
Phone ( )	Type of account: ☐ Checking ☐ Savings		

C. ERA Enrollments

Are you planning on using a Clearing House to receive your ERA? ☐ Yes ☐ No

If yes, provide the Clearing House name_____

Method in which you will receive the ERA: ☐ Website ☐ Other

D. EFT/ERA Consent

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 under the heading "Banking/Financial Institution Information" above, 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 thirty (30) 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 connection 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/Financial Institution 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. Contact your financial institution to arrange for the delivery of the CORE-related Minimum CCD+ Data Elements necessary for successful re-association of the EFT payment with the ERA remittance advice.

CONTINUED ON NEXT PAGE

DELTA DENTAL®

Direct Deposit Enrollment Form

E. New Authorization

I authorize and request Delta Dental of Virginia (hereinafter called DDVA) to send the net claims check directly to my bank or other financial institution as specified in Section B of this form. I understand that by doing this, I will begin receiving an ERA statement as an Explanation of Benefits (EOB). I understand I may terminate this agreement at any time by completing another "Direct Deposit Authorization" or in any event by sending a thirty (30) day written notice to terminate (with new request/instructions for future payment).

Dentist Signature_____ Date signed_____

F. Change Authorization Statement

I authorize and request DDVA to make the changes indicated on this form. I will allow DDVA thirty (30) days from date of receipt of this document to accomplish these changes.

Dentist Signature_____ Date signed_____

G. Cancellation Statement

I authorize and request DDVA to terminate authorized direct deposits to my account. By doing this, I understand that I will no longer receive an Explanation of Benefits (EOB) through an ERA statement. I understand that all future payments will be made via a paper check and that ERA statements will come in the form of a paper EOB. I will allow DDVA a thirty (30) day notice from receipt date of this document to accomplish these changes. Unless otherwise noted, upon such cancellation, (future) payments will be made to the participating dentist.

Dentist Signature_____ Date signed_____

H. This step is EXTREMELY important, as your application cannot be processed without a voided check*.

Indicate the validation attached: ☐ Voided check ☐ Your bank's letterhead with account and routing numbers. *A voided check is not required if there are no changes to your banking/financial institution information.*

For questions, or to check the status of the change in our system, contact Provider Relations at 800.367.3531, extension 3328.