



Dental  
Wellness  
Partners<sup>SM</sup>

## Getting Started

To become a participating provider with Dental Wellness Partners, you must complete the enclosed forms and submit certain additional information. It is important that the forms be complete and accurate.

Please use the checklist below to ensure we have all of the information we need to process your application efficiently.

- Provider Agreement (tear-out)**  
If owner is signing for a group practice, only one agreement is necessary. However, all dentists who wish to participate must complete the Dentist Credentialing Information form and sign the Attestation Statement.
- Office Profile (tear-out)**  
Complete one Office Profile form for each service address to be listed.
- Dentist Credentialing Information (tear-out)**  
Each dentist in your practice who wishes to participate must complete one of these forms. Copies of this form are permitted.
- Copy of current state dental license**  
Please provide a copy for each dentist applying.
- Copy of professional liability insurance**  
Please send a copy of the face sheet showing coverage amounts, expiration date, and provider/business name for each dentist.
- W-9 Form (tear-out)**  
Please be sure to indicate your practice/business start date.

*Upon acceptance as a Dental Wellness Partners participating provider, a copy of the fully executed Network Participation Agreement will be mailed to the service address for your records.*



# Network Participation Agreement

## 1. Dental Wellness Partners (“DWP”)

This agreement is between Dental Wellness Network, LLC, and the dentist, professional corporation, or group practice (hereafter “Dentist”). Dentist shall become a participating dentist in Dental Wellness Partners preferred dental network (hereafter “DWP Network”). This Participation Agreement, along with the attached Application/Credentialing Form and Attestation Statement (collectively referred to as “this Agreement”), shall govern the obligations of DWP Network participating dentists.

## 2. Services to be Provided

By signing this Agreement, Dentist agrees to provide dental treatment to eligible subscribers on the basis of two components: 1) A subscriber’s eligibility for services from DWP Network dentists via contractual agreements with an employer, insurance company, third-party payor, or other entity (collectively referred to as the “Payor”) or 2) A subscriber’s eligibility for services from DWP Network dentists via the use of an Access Card (both components collectively referred to as “DWP Programs”). During Dentist’s participation in DWP Network, Dentist shall personally furnish all reasonably required professional dental services of a quality and frequency called for according to generally accepted patterns of practice of dentistry in a timely manner to eligible individuals (hereafter “DWP Subscribers”) who present themselves to Dentist under DWP Programs, and shall provide other dental services customarily provided by dental offices, such as prophylaxes and radiographs, in accordance with generally accepted patterns of practice of dentistry.

## 3. Dentist Compensation

Dentist agrees that Dentist’s charges to DWP Subscribers shall be the fees specified in the attached fee schedule (which will be updated from time to time), regardless of whether the service is a covered benefit or not. Dentist agrees to accept this as payment-in-full, including any applicable co-payments, coinsurance, or deductibles that Dentist is obligated to collect and agrees not to waive. Dentist agrees:

- A. When Dentist accepts payment from a Payor, Dentist may not charge or collect from the DWP Subscriber any amount obligated to be paid by the Payor or in contradiction of any provision of this Agreement or the attached fee schedule, provided this does not prohibit Dentist from charging and collecting applicable co-payments, coinsurance, or deductibles authorized by DWP Programs.
- B. When Dentist accepts the presentation of an Access Card from a DWP Subscriber, Dentist may collect fees directly from the DWP Subscriber but not in contradiction of any provision of this Agreement, the attached fee schedule, or the applicable DWP Program.
- C. When Dentist provides dental treatment for a non-covered service, Dentist may collect fees directly from the DWP Subscriber. Dentist expressly agrees not to charge or collect any fees from the DWP Subscriber above the allowed amount provided on the fee schedule for non-covered services.
- D. Dentist acknowledges that DWP shall not be liable for any payments due to Dentist including, but not limited to, claim payments from Payor or payments from DWP Subscribers.
- E. Dentist shall not charge or collect any fees from a DWP Subscriber or Payor for completing paperwork or any late fees on amounts due from Payors.

## 4. Dentist Records and Cooperation

Dentist shall maintain complete and detailed patient treatment and financial records which shall be made available to Payor or DWP for review upon request. Such records shall be preserved for seven years. Dentist shall cooperate with DWP’s utilization review, credentialing, and re-credentialing, as well as with any grievance procedures that may follow.

## 5. Eligible Subscribers

Persons who present proof of eligibility in a DWP Program at the time services are rendered will be deemed by Dentist to be DWP Subscribers.

## 6. Assignment

Dentist may not assign this Agreement or any rights accruing to Dentist under this

Agreement to any other party without the written consent of DWP. DWP may assign this Agreement to one or more affiliated entities or subsidiaries and may make other entities third-party beneficiaries to this Agreement. Any such action shall be effective when Dentist receives written notice from DWP.

## 7. Non-exclusive Agreement

This Agreement is non-exclusive and DWP may enter into similar agreements with other dentists, and Dentist may enter into similar agreements with other parties.

## 8. Independent Contractor

Dentist is an independent contractor with DWP. Dentist shall maintain the customary dentist-patient relationship for eligible DWP Subscribers treated by Dentist.

## 9. General Requirements of DWP Network Participation

Dentist may not submit or cause to be submitted to Payor any Dental Claim Form for dental services or any other statement which contains false or misrepresented information. False or misrepresented information includes, but is not limited to, misinformation concerning dates services are performed. Only completion dates for services are acceptable: for example, the delivery date of partial or complete dentures, the cementation date of crowns or bridgework, or the date of the final fill of a root canal. Dentist agrees to cooperate fully with DWP Network credentialing committee and/or consultants designated by DWP to review professional standards relative to care provided by Dentist to an DWP Subscriber. The decision of any such consultant or committee, subject to any applicable appeal process, shall be binding on Dentist. DWP reserves the right to terminate Dentist’s Participation Agreement for violation of any of the below listed items.

- A. Dentist shall submit claims for services within six (6) months after the date the service is provided. If Payor denies a claim due to late submission, the DWP Subscriber shall not be liable to Dentist for the amount that would have been payable by Payor had the claim been submitted in a timely fashion, provided the DWP Subscriber advised Dentist of DWP Program coverage at the time of treatment.
- B. Any violation of this Agreement may be deemed to be a breach of this Agreement and may result in termination.
- C. A Dentist who has lost his/her participating status, after complying with any and all conditions imposed by DWP, may apply for reinstatement in the same manner as if the dentist were a first-time applicant.
- D. Termination of Dentist’s Participation Agreement shall not relieve Dentist of any obligation incurred under the Participation Agreement while it was in force.
- E. Dentist authorizes Payor to deduct from any payments due him/her such sums as Payor reasonably determines to be properly due and owing to Payor as a refund of payments incorrectly made to or claimed by Dentist.

## 10. Entire Agreement

This Participation Agreement along with the Application/Credentialing Form and Attestation Statement constitute the entire contract between DWP and Dentist.

## 11. Termination

This Agreement may be terminated by either party, with or without cause, upon thirty (30) days written notice to the other. This Agreement will automatically terminate in the event Dentist’s license to practice dentistry in the state of practice is limited in any way or if Dentist’s conduct may result in immediate injury or damage to the health, safety, or well-being of any DWP Subscriber, subject to a final determination by DWP Network credentialing committee. All notices of termination are to be sent to the last known address of the other party with the postage prepaid and by certified mail, return receipt requested.

## 12. Changes

DWP will notify Dentist in writing of any change to this Agreement. The change will become effective immediately unless Dentist notifies DWP that the change is unacceptable. DWP will deem such a notice by Dentist as a request to terminate this Agreement.

## 13. Group Practices

If a group practice is a party to this Agreement:

- A. The group practice assumes all the duties and obligations of “Dentist” in this Agreement.
- B. The group practice shall keep a record of the persons who perform dental services for each DWP Subscriber, the nature of such dental services, and the date such services were performed.

- C. The group practice shall identify all dentists performing dental services at the group practice and provide DWP with any changes as they occur. The group practice, whether a corporation, an assumed name, a partnership, a limited partnership, a joint venture, or other form of legal entity, shall be the responsible party for complying with this Agreement.
- D. All payments for services rendered to DWP Subscribers treated at the group practice shall be paid to the group practice. The group practice shall make its own financial arrangements with individuals, both dentists and non-dentists, who provide dental and related services, and Payor shall have no responsibility to such individuals.

**14. Severability of Unlawful Provisions and Effect of Waiver**

If any of the provisions of this Agreement are or become contrary to law, such provisions shall be inoperative, but the remainder of this Agreement shall remain in full force and effect. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, nor be construed as, a waiver of any subsequent breach.

**15. Headings**

Section headings are for convenience only and are not to be used in construing the intent of this Agreement.

**16. Dentists Continued Representations and Warranties**

Dentist represents and warrants that Dentist is licensed to practice dentistry in the state of practice and that such license has not been suspended, revoked, limited, or sanctioned within the past five (5) years. Dentist further represents and warrants that Dentist’s staff and facilities are licensed as required under law. All of Dentist’s rights and obligations under this Agreement are conditioned on the continued maintenance of Dentist’s license with no restrictions. Dentist agrees to notify DWP immediately if there is any change in Dentist’s or staff’s licensure, representations, or warranties. Dentist agrees to notify DWP in writing within 10 business days of said changes.

**17. Confidentiality**

Dentist shall not, except with DWP’s express consent, use or disclose to any person, firm, or corporation, whether in competition with DWP Network or not, any knowledge or information not in the public domain concerning DWP Network. It is also understood that neither Dentist nor Dentist’s employees will disclose to DWP other confidential information belonging to any third party. Dentist’s obligation with respect to confidentiality, as set forth immediately above, shall remain in force for a period of three years following termination of this Agreement. Dentist agrees that DWP may include the following in its directories and lists of DWP Network participating dentists: Dentist’s name, business name, address, telephone number, professional designations, and other pertinent information regarding hours, access, and services provided. DWP does not guarantee in any way that DWP Subscribers will use Dentist or that Dentist will receive any minimum number of DWP Subscribers. Dentist also agrees and consents that DWP may share this information with Payor.

**18. Indemnification**

DWP and Dentist agree to indemnify, defend, and hold harmless the other, its directors, officers, employees, agents, parents, affiliates, subsidiaries, successors, and assigns from and against any and all liabilities, claims, suits, actions, demands, settlements, losses, judgments, costs, damages, and expenses (including reasonable attorneys’ fees) arising out of or resulting from, in whole or in part, any acts, errors, or omissions of the other, its employees, agents, or contractors in performing or failing to perform under this Agreement, or any inaccuracy or breach of any representation or warranty of the parties.

**19. Network Use**

By signing the Application/Credentialing Form, Dentist agrees to be included in the directories and lists of DWP Network participating dentists that will be made available to current and prospective DWP Subscribers and clients.

**20. Notice**

Except as otherwise provided, all notices required or deemed necessary under this Agreement shall be in writing and be served either 1) by facsimile, 2) by electronic signature, or 3) by first class mail. Until notice of a change of address is given, all such notices and documents should be given or addressed to Dentist at the address provided on the Application/Credentialing Form and to DWP at the following address:

Dental Wellness Partners  
 PO Box 17160  
 Indianapolis, IN 46217

**21. Arbitration**

Any disputes arising from this Agreement shall be referred and decided by binding arbitration as governed by the American Arbitration Association with each party bearing equal costs of the proceeding.

**22. Governing Law**

This Agreement shall be governed under the laws of the state of Michigan provided that this Agreement shall be deemed to incorporate any terms and provisions required to be included by statute or regulation of the state where Dentist is located, and such required terms and conditions shall supersede any conflicting provisions herein.

**23. Professional Liability Coverage**

Dentist agrees to have in full force and effect during and after the term of this agreement, professional liability insurance with respect to the services provided hereunder (“Malpractice Insurance”). Dentist shall immediately notify DWP of any restrictions of such Malpractice Insurance.

**24. Membership**

Dentist shall become a member of the DWP Network and shall be entitled to all rights and privileges of such membership, including access to all products and services which DWP has arranged to be provided to DWP Network Dentists from time to time, for so long as this Agreement is in effect.

**25. Attestation Statement**

The signed attestation statement must be read in conjunction with this agreement.

*A photocopy or fax of this agreement shall be as valid as the original.*

IN WITNESS WHEREOF, Dental Wellness Network, LLC, and Dentist have executed this Agreement as of the latest date shown below.

**Dentist**

By \_\_\_\_\_  
 (Authorized Signature)

\_\_\_\_\_  
 (Name/Title of Above - Please Print)

Date \_\_\_\_\_

\_\_\_\_\_  
 (Name of Practice, Group or Corporation) - Please Print

SS# \_\_\_\_\_ Tax ID# \_\_\_\_\_

State License # \_\_\_\_\_

**Dental Wellness Network, LLC**

By \_\_\_\_\_  
 (Authorized Signature)

\_\_\_\_\_  
 (Name/Title)

Date \_\_\_\_\_



## Office Profile

Please type or print all of the information requested on this form. Incomplete forms cannot be accepted and will be returned for completion. List only the locations at which you will treat members under this Agreement. ***If multiple locations, copy form and complete for each location.***

### Section 1: Participating Dental Office Information

Business Name \_\_\_\_\_ (W-9 business name) NPI \_\_\_\_\_ (Practice Identifier)

Practice/Dentist Name \_\_\_\_\_ (As will be listed in directory) Practice Start Date \_\_\_\_\_

Service Office Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_ Phone \_\_\_\_\_

Fax \_\_\_\_\_ Email \_\_\_\_\_ Tax ID \_\_\_\_\_

Payment address (if different than service address)

Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_ Phone \_\_\_\_\_

Physically Disabled Access:  Yes  No Languages other than English (list) \_\_\_\_\_

Do you follow the current recommendations of the American Dental Association and the Centers for Disease Control and Prevention regarding infection control? . . . . .  Yes  No

If no, explain: \_\_\_\_\_

Do you comply with the Occupational Exposure to Blood borne Pathogens Standards of the OSHA regulations? . . .  Yes  No

If no, explain: \_\_\_\_\_

### Section 2: Group Practice Members, Partners, and Associates

The following agree to be bound by all provisions of this Agreement. Dentist is responsible and agrees to notify Dental Wellness Partners of any changes in this list. **A Dentist Credentialing Information sheet and Attestation must be completed for each provider.**

| First Name | Last Name | MI    | Degree | License # | Specialty |
|------------|-----------|-------|--------|-----------|-----------|
| _____      | _____     | _____ | _____  | _____     | _____     |
| _____      | _____     | _____ | _____  | _____     | _____     |
| _____      | _____     | _____ | _____  | _____     | _____     |
| _____      | _____     | _____ | _____  | _____     | _____     |
| _____      | _____     | _____ | _____  | _____     | _____     |



Dental Wellness Partners

### Dentist Credentialing Information

Please complete all items to avoid having the application returned. This form may be copied for each additional dentist in the practice who wishes to participate.

Please provide the following information:

- Current Professional Liability Face Sheet showing coverage amounts, expiration date, and provider name
Copy of Current State Dental License
Current State License Number State Expiration Date
Other Current State License Number State Expiration Date
Federal DEA # (if applicable) Expiration Date
State DEA # (if applicable) Expiration Date

Last Name First Name MI DDS/DMD/Other
Specialty SSN# Date of Birth Gender
National Provider Identifier (NPI)

Professional Liability Insurance

Carrier(s) Name Policy #
Limits of Coverage \$ /\$ Effective Date Expiration Date

Professional Information

- Have you ever been involved in a malpractice suit or claim or do you have any claims pending?
Has your license to practice dentistry in any state ever been revoked, suspended, restricted, limited, or placed in a probationary state?
Have you ever been reprimanded, disciplined, counseled, or been subject to similar action by any state licensing agency with respect to your license to practice?
Are you currently under any investigation with respect to your Drug Enforcement Agency (DEA) license or has your DEA license ever been revoked, suspended, or placed on probation?
Have you ever been subject to sanctions by Medicare, Medicaid or any other state or federal program?
Have you ever been convicted of a felony or do you have any criminal charges pending other than for minor traffic offenses?

If you answered yes to any of these questions, please provide an explanation on a separate sheet. If possible, please supply an NPDB self queried report(s).

### Dentist Attestation Statement

By signing below, I hereby apply to become a participating dentist in Dental Wellness Partners (DWP) dental network. I understand and agree that my execution and submission of the Agreement grants me no rights or privileges of participation until such time as I receive written notification from DWP signifying DWP's acceptance of me or my group practice as a participating dentist(s).

I authorize the State Board (or other dental licensing agencies in any state in which I am licensed to practice dentistry) and any health care facility, health maintenance organization or professional organization with whom I have had employment, practice, association or privileges, to release information to DWP regarding my professional skills, any pending or final disciplinary action or malpractice action, and any other information relevant to my character or professional competence.

I understand that DWP may require me to provide credentialing information, as necessary, in connection with this application.

I certify that all of the information herein is accurate and true to the best of my knowledge and agree to notify DWP, in writing, of any changes in this document within 10 days of their occurrence.

Applicant Signature

Print Name

Date

Please complete the following information. Federal law requires Dental Wellness Network, LLC to obtain this information when making reportable payment(s) to you. Failure to provide this information may result in a 28 percent federal income tax backup withholding applied to your payments, and you may be subject to a \$50.00 penalty imposed by the Internal Revenue Service under section 6723.

Instructions: Complete Part 1: Complete the row of boxes that corresponds to your tax status  
 Complete Part 2: Complete only if you are exempt from Form 1099 reporting  
**Complete Part 3: Sign and date the form, and return it to Dental Wellness Partners in the enclosed envelope.**

**PART 1 Tax Status** (Complete one row of boxes only)

**Individuals**

|                   |                                     |
|-------------------|-------------------------------------|
| Individual's Name | Individual's Social Security Number |
|-------------------|-------------------------------------|

**Sole Proprietor**

Note: A sole proprietor may have a "doing business as" trade name, but the legal name is the name of the business owner as it appears on your Social Security card

|  |  |                                 |
|--|--|---------------------------------|
| Business Owner's Name<br>(legal name as it appears on tax documents) | Business Owner's Social Security Number or TIN | Doing Business As or Trade Name |
|--|--|---------------------------------|

**Partnership**

|  |  |                                 |
|--|--|---------------------------------|
| Name of Partnership<br>(legal name as it appears on tax documents) | Partnership's Employer Identification Number | Doing Business As or Trade Name |
|--|--|---------------------------------|

**Corporation, Exempt Charity or Other Entity**

Note: A corporation may use an abbreviated name or its initials elsewhere, but its legal name is the name as it appears on the IRS EIN (employer identification number) confirmation letter.

|  |                                |
|--|--------------------------------|
| Name of Corporation or Entity (legal name) | Employer Identification Number |
|--|--------------------------------|

**PART 2 Exemption** If exempt from form 1099 reporting, check the box and circle the qualifying reason below.

- 
1. Corporation – however, there is NO exemption for medical and health care payments or payments for legal services
  2. Tax Exempt Charity under 501(a), or IRA
  3. The United States or any of its agencies or instrumentalities
  4. A state, the District of Columbia, a possession of the United States or any of their political subdivisions
  5. A foreign government or any of its political subdivisions

**PART 3 Certification**

Effective date for above business (practice start date) \_\_\_\_\_

Signature of person completing this form \_\_\_\_\_

Name and title of person completing this form (please type or print) \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date \_\_\_\_\_ Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_