DELTA DENTAL

Address Change Information

This form is to be used when the office has moved physical locations. The change will be made in our system as soon as we receive the appropriate forms. It's important to submit changes in a timely manner to avoid delays in claims processing. Please note, non-participating providers do not need to complete any forms related to Medicare Advantage.

Please complete this form in its entirety and return via one of the options listed below:
Email: **profservices677@ddpco.com**
Fax: 303-741-2230

Legal Business Name:
Doing business as (DBA):
Tax ID Number (TIN) submitted on claims for this location:
Type 2 Facility National Provider Identifier (NPI):
Old address:
Term date of old address:
New address:
Effective date of new address:
Billing/Payment address:
Main office email address (DDCO newsletters, fee schedules, etc.):
Credentialing email address (for recredentialing notices):
Office website URL address:
Phone:
Fax:

Office hours: Mon Tues Wed Thurs Fri

Sat Sun

Are you accepting new patients? ◯ Yes ◯ No

Languages spoken (other than English):

Treats physically disabled adults? ◯ Yes ◯ No

Treats physically disabled children? ◯ Yes ◯ No

Name all dentists at the new location, under this TIN, and which products they will participate in:

Name:
License Number:
Type 1 individual NPI:

☐ Delta Dental Premier® ☐ Delta Dental PPO Plus Premier™ ☐ Delta Dental Medicare Advantage™

☐ Non-participating Provider

Is this the providers primary location? ◯ Yes ◯ No

If not, what is the Location Name/Address:

Name:
License Number:
Type 1 individual NPI:

☐ Delta Dental Premier® ☐ Delta Dental PPO Plus Premier™ ☐ Delta Dental Medicare Advantage™

☐ Non-participating Provider

Is this the providers primary location? ◯ Yes ◯ No

If not, what is the Location Name/Address:

Name:
License Number:
Type 1 individual NPI:

☐ Delta Dental Premier® ☐ Delta Dental PPO Plus Premier™ ☐ Delta Dental Medicare Advantage™

☐ Non-participating Provider

Is this the providers primary location? ◯ Yes ◯ No

If not, what is the Location Name/Address:

Name:
License Number:
Type 1 individual NPI:

☐ Delta Dental Premier® ☐ Delta Dental PPO Plus Premier™ ☐ Delta Dental Medicare Advantage™

☐ Non-participating Provider

Is this the providers primary location? ◯ Yes ◯ No

If not, what is the Location Name/Address:

Name:
License Number:
Type 1 individual NPI:

☐ Delta Dental Premier® ☐ Delta Dental PPO Plus Premier™ ☐ Delta Dental Medicare Advantage™

☐ Non-participating Provider

Is this the providers primary location? ◯ Yes ◯ No

If not, what is the Location Name/Address:

Name:
License Number:
Type 1 individual NPI:

☐ Delta Dental Premier® ☐ Delta Dental PPO Plus Premier™ ☐ Delta Dental Medicare Advantage™

☐ Non-participating Provider

Is this the providers primary location? ◯ Yes ◯ No

If not, what is the Location Name/Address:

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.

DELTA DENTAL

Provider Direct Deposit Enrollment Form

Please fax or email this form to:
(f) 303.741.2230 Attn: Provider Relations
(e) **profservices677@ddpco.com**

Reason for submission

☐ **New EFT/ERA Authorization:** Complete sections A, B, C, D	
☐ **Cancel EFT/ERA:** Complete sections A & F	
☐ National EFT (All Delta Dental)	☐ Local EFT (Colorado Only)

☐ **Changes to an existing EFT/ERA Authorization**: Complete sections A, B, D, E, G	
☐ National EFT (All Delta Dental)	☐ Local EFT (Colorado Only)

A. Provider Information

Provider Complete Legal Name:	Practice Name:	
Location Address:	City, State, ZIP Code:	
Phone Number:	Fax Number:	
Name of Office Contact:	Provider's Email Address:	
National Provider Identifier (NPI1) if applicable:		
*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

☐ I want different accounts for different locations. I'm submitting a separate enrollment for each location.

B. Banking/Financial Institution (Please print or Type)

Financial Institution's Name:	
Account Number:	Routing Number:
Address:	City, State, ZIP Code:
Telephone Number:	Type of Account: ☐ Checking ☐ Savings
	Account Number Linkage to Provider ID: ☐ Provider TIN ☐ NPI

C. EFT/ERA Consent

In consideration for the provision of direct deposit services, by signing below, and not withstanding 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 inform tion 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.

D. New Authorization

I authorize and request Delta Dental of Colorado (hereinafter called DDCO) 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:**

E. Change Authorization Statement

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

Dentist Signature: **Date Signed:**

F. Cancellation Statement

I authorize and request DDCO 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 DDCO 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:**

G. This step is EXTREMELY important, as your application cannot be processed without avoided check.

Please mark the validation attached/scanned:

☐ A voided check ☐ Your bank's letterhead with account & routing numbers

A voided check is not required if there are no changes to your Banking/Financial Institution information.

DELTA DENTAL

ADDENDUM TO PARTICIPATION AGREEMENT FOR MEDICARE ADVANTAGE PLANS

THIS ADDENDUM is entered into effective as of the "Addendum Effective Date" on the signature page, by and between Delta Dental of Colorado ("Delta Dental") and the Participating Dentist named on the signature page.

WHEREAS, Delta Dental contracts with insurance companies and health maintenance organizations that are approved by the Center for Medicare & Medicaid Services ("CMS") as Medicare Advantage Organizations ("MAOs"), to arrange for the delivery of dental services and to provide administrative services related thereto, for enrollees of the Medicare Advantage Plans offered by the MAOs (the "MA Plans");

WHEREAS, Participating Dentist desires to be a Participating Dentist in the MA Plans;

WHEREAS, Delta Dental and Participating Dentist are parties to a Participating Provider Agreement ("Participation Agreement"), which together with Delta Dental's Provider Handbook (as referenced in the Participation Agreement, the "Provider Handbook") and this Addendum sets forth the terms and conditions by which Participating Dentist will provide dental services to the enrollees of the MA Plans; and

WHEREAS, the Parties desire to incorporate this Addendum into the Participation Agreement.

NOW THEREFORE, pursuant to Paragraph 10 of the Participation Agreement, which allows the Participation Agreement to be amended, Delta Dental and Participating Dentist do hereby agree to the following with regard to the MA Plans.

A. **Definitions.** In addition to the definitions set forth in this Addendum, all defined terms shall have the meanings ascribed to them in the Participation Agreement.

1. "Centers for Medicare and Medicaid Services" or "CMS" means the agency within HHS that administers the Medicare program.

2. "Clean Claim" means a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

3. "Completion of an Audit" means the completion of an audit by HHS, the Government Accountability Office, or their designees, of an MAO, MAO contractor or Related Entity.

4. "Dental Services" means those services, including diagnostic, therapeutic, evaluative and preventive services, which are generally and customarily provided to patients by dentists and the provision of certain appliances and supplies incidental to the performance of such services, that are covered by the applicable MA Plan.

5. "Downstream Entity" means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between an MAO, or an MAO applicant, and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

6. "Final Contract Period" means the final term of the contract between CMS and the MAO.

7. “First Tier Entity” means any party that enters into a written arrangement, acceptable to CMS, with an MAO, or MAO applicant, to provide administrative services or health care services for a Medicare eligible individual under the MA program.

8. “HHS” means the U.S. Department of Health and Human Services.

9. “Medicare Advantage” or “MA” means an alternative to the traditional Medicare program in which private plans run by health insurance companies or health maintenance organizations provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

10. “Medicare Advantage Organization” or “MAO” means a public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

11. “MA Enrollee” means a Medicare Advantage eligible individual who has enrolled in or elected coverage through an MA Plan.

12. “MA Plan Participating Dentist Manual” means the handbook developed by Delta Dental which governs the obligations of Delta Dental and Participating Dentist for the MA Plans. The MA Plan Participating Dentist Manual is incorporated by reference into the Participation Agreement and is available at www.deltadentalco.com. The MA Plan Participating Dentist Manual can be modified by Delta Dental from time to time.

13. “Preclusion List” means the list maintained by CMS under 42 C.F.R. § 422.222 and defined in 42 C.F.R. § 422.2.

14. “Related Entity” means any entity that is related to the MAO by common ownership or control and (1) performs some of the MAO’s management functions under contract or delegation; (2) furnishes services to MA Enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

B. Requirements For MA Plans

1. Participating Dentist agrees to participate in the MA Plans identified by Delta Dental and to accept payment identified by Delta Dental as payment in full for Dental Services to MA Enrollees (the “Covered Services”). Delta Dental will provide Participating Dentist with information regarding each MA Plan including such things as name of the MA Plan, counties where the MA Plan products will be marketed, summary of the MA Plan benefits, and applicable fee schedule.

2. Participating Dentist shall provide Covered Services in compliance with the terms of the MA Plans, the Provider Agreement, the Provider Handbook, and the MA Plan Participating Dentist Manual.

3. If Delta Dental or an MAO is determined to be insolvent by a court with jurisdiction over such matters, Participating Dentist will continue to provide Covered Services through the period for which premium has been paid by or for MA Enrollees.

4. In addition to the requirements set forth in the Provider Agreement and Provider Handbook (including but not limited to requirements regarding credentialing and quality assurance), Delta Dental shall monitor the performance of Participating Dentist and Participating Dentist shall comply with all policies and procedures established by Delta Dental to monitor the provision of the Covered Services by Participating Dentist to MA Enrollees to ensure compliance with Federal statutes, rules and guidance applicable to the MA Plans.

5. All Covered Services, and any other services or other activity performed by Participating Dentist, shall be consistent and comply with the MAO's contractual obligations under the MAO's agreement with CMS.

6. Delta Dental shall pay Clean Claims within 30 days of receipt and if a Clean Claim is not paid within 30 days Delta Dental shall pay interest in accordance with applicable prompt pay regulations.

7. Participating Dentist acknowledges that MA Plans are governed by Federal law, regulation and guidance issued by CMS. Participating Dentist understands that the specific terms of this Addendum are subject to amendment in accordance with changes to the Medicare Advantage program effectuated by statute, regulation, or CMS guidance. An amendment required for compliance therewith shall not require the consent of Participating Dentist and will be effective on the date identified by Delta Dental.

8. Participating Dentist acknowledges that HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer, or other electronic systems related to CMS's contract with an MAO through 10 years from the final date of the Final Contract Period or from the date of Completion of an Audit, whichever is later.

9. Participating Dentist shall comply with the confidentiality and enrollee record accuracy requirements, including:
    (a) Abiding by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information;
    (b) Ensuring that medical information is released only in accordance with applicable Federal or state law, or pursuant to court orders or subpoenas;
    (c) Maintaining the records and information in an accurate and timely manner; and
    (d) Ensuring timely access by MA Enrollees to the records and information that pertain to them.

10. Participating Dentist shall not hold MA Enrollees liable for payment of any amounts that are the legal obligation of Delta Dental or an MAO.

11. For any MA Enrollees eligible for both Medicare and Medicaid, MA Enrollees shall not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Participating Dentist will be informed of Medicare and Medicaid benefits and rules for MA Enrollees eligible for Medicare and Medicaid. Participating Dentist may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Medicaid if the individual were not enrolled in such a plan. Providers will: (a) accept the payment from the MAO or Delta Dental as payment in full, or (b) bill the appropriate state source.

12. Participating Dentist shall comply with all applicable Medicare laws, regulations and CMS guidance and any other applicable federal, state and local laws and regulations, and all amendments thereto, including, but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act. Participating Dentist understands and agrees that this Addendum shall be deemed automatically amended as necessary to comply with any applicable state or federal regulation, or any applicable provision of the MAO's contract with CMS.

13. Participating Dentist shall comply with the MA Plan Participating Dentist Manual which shall include Delta Dental's compliance program and program integrity activities, including providing documentation of completion and access to records as necessary for audits by Delta Dental, HHS, and other federal governmental agencies with jurisdiction over such matters.

14. Participating Dentist shall not use any policy or practice that has the effect of discriminating among MA Enrollees on the basis of race, color, national origin, sex, sexual orientation, gender identity, disability, or status as an MA Enrollee. This includes accepting MA Enrollees as a new patient if Participating Dentist is accepting any new patients and making appointments for them equally available.

15. Participating Dentist shall abide by the prohibition on payments for provider-preventable conditions, as set forth in the MA Plan Participating Dentist Manual and federal regulation at 42 C.F.R. § 447.26.1

16. Participating Dentist shall deliver services in a culturally competent manner to all MA Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

17. Participating Dentist shall provide physical access, reasonable accommodations, and accessible equipment for MA Enrollees with physical or mental disabilities.

18. Participating Dentist shall retain all records related to MA Enrollees for at least ten (10) years following the termination of the Participation Agreement.

19. Participating Dentist may terminate this Addendum without cause and without terminating the Agreement (and your participation in Delta Dental's other networks) upon sixty (60) days' prior written notice to Delta Dental by following the notice requirements in the Participation Agreement. Your notice of termination will only be effective for the networks or programs specified in your notice.

20. This Addendum may be terminated immediately by Delta Dental if Participating Dentist is:
    (a) excluded from participation in Medicare;
    (b) placed on the Preclusion List;
    (c) opts-out of Medicare by filing an affidavit under Section 1802(b) of the Social Security Act; or
    (d) elects to terminate his/her status as a participating dentist in the MA Plans.

[1] Under existing law, examples of a provider preventable condition are the wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, surgical or other invasive procedure performed on the wrong patient, and unintended retention of a foreign object

The termination shall be effective as of the date of any such occurrence. Any payments made to Participating Dentist for Covered Services provided after the effective date of the termination shall be promptly returned to Delta Dental.

21. Upon a specific written request of CMS, this Addendum will be amended to exclude any MA plan or state-licensed entity specified by CMS.

22. In addition to the representations set forth in the Provider Handbook, Participating Dentist represents to Delta Dental that each of the following representations is currently true, accurate and complete and will remain true, accurate and complete throughout the term of the Participation Agreement: (a) Participating Dentist has not opted-out of Medicare by filing an affidavit under Section 1802(b) of the Social Security Act; and (b) Participating Dentist is not on the Preclusion List. Participating Dentist shall immediately notify Delta Dental if Participating Dentist is excluded from participation in any Federal health care program or is placed on the Preclusion List.

23. In the event of a conflict between the terms of the Participation Agreement and/or the Provider Handbook and this Addendum, the terms of this Addendum shall control with respect to MA Plans and MA Enrollees.

This Addendum may be executed in counterparts (and by electronic means) and returned by Participating Dentist to Delta Dental via facsimile or email.

IN WITNESS WHEREOF, the parties have executed this Addendum to be effective, and supplement the Participation Agreement, as of the "Addendum Effective Date" set forth below.

ADDENDUM EFFECTIVE DATE:

(To Be Completed by Delta Dental Only. Dentist will be notified in writing by Delta Dental of the Effective Date.)

PARTICIPATING DENTIST NAME:

LOCATIONS:

By:

Name of Signatory:

Title:

DELTA DENTAL OF COLORADO

DELTA DENTAL

Delta Dental of Colorado
Medicare Advantage Yearly Compliance Attestation Form

Delta Dental of Colorado's compliance program is our commitment to business integrity and ethical behavior. Part of this commitment is ensuring we are in full compliance with our obligations and responsibilities as a First-Tier entity to the Medicare Advantage Organizations (MAO) with which we contract. Your written agreement with Delta Dental of Colorado, as the ultimate provider of health or administrative services for Medicare Advantage dental benefits, means your organization is considered a downstream entity. Delta Dental of Colorado is required to monitor and ensure your organization operates in compliance with applicable laws and regulations required by the Centers for Medicare and Medicaid Services (CMS) and your contract with Delta Dental of Colorado.

As part of DDCO's commitment to adhering to all Centers for Medicare & Medicaid Services (CMS) regulations, it is essential that any downstream entity, including your dental office, complies with the same rules and regulations.

In 2024, CMS provided clarification regarding regulation 42 CFR § 422.105. We want to ensure you are fully informed of this provision and its requirements. According to 42 CFR § 422.105 and the Medicare Managed Care Manual (MMCM), members/patients must be notified in advance if a covered service will be denied based on the plan benefits provision. If notice is not provided (typically via a predetermination of benefits or patient consent form), the member/patient cannot be held liable for the amount the carrier would have paid. This amount becomes a write-off/adjustment for the contracted Delta Dental Medicare Advantage provider. However, the patient remains liable for the amount calculated per the cost-sharing provisions.

For more information regarding this regulation and others, please visit CMS at **CMS.gov** and search for 42 CFR § 422.105.

By signing this attestation, you are affirming your commitment to comply with each of the listed topics that apply to your organization(s) and the services you provide for Medicare Advantage business. You are signing this attestation as part of the required attestation process, your participation in the Delta Dental Medicare Advantage network is active for all locations where you provide treatment for Medicare Advantage members. Please include all locations at which you will be part of the Delta Dental Medicare Advantage network.

Fraud, Waste, and Abuse (FWA) and General Compliance Training

My organization provides all employees and subcontractors fraud, waste, and abuse and general compliance training* within 90 days of hiring and annually thereafter. The following training modules are incorporated into our training and/or written documents:

- **Combating fraud in federal health care programs**

Report FWA and Non-Compliance or HIPAA Issues

My organization understands that it must report any suspected or known FWA or non-compliance or HIPAA concerns to Delta Dental of Colorado's hotline at 1-833-430-0255, **compliance@ddpco.com**, or go to **deltadentalco.com/members/fraud-abuse-form** on Delta Dental of Colorado's website to complete and submit the Fraud, Waste, and Abuse form, so that reports can be made to all impacted MAOs. My organization has communicated to employees and subcontractors on how to report the suspected or known FWA or non-compliance concerns and that they are obligated to do so without fear of retaliation or intimidation.

Office of Inspector General (OIG) and General Services Administration (GSA) Exclusion Screening

My organization and I review the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and General Services Administration (GSA) List for our employees, temporary employees, board members, volunteers, and contractors involved in the administration and delivery of services to Medicare Advantage enrollees.

Exclusion screenings from these sources are checked prior to initial hire or contracting and monthly thereafter. Any individual found on such lists will immediately be removed from any work directly or indirectly related to Medicare Advantage programs.

- OIG Exclusion List
- GSA Exclusion List

Record Retention

My organization and I agree to maintain records of compliance training, disciplinary standards, investigations, compliance program materials, and exclusion checking for all employees, including temporary employees and volunteers, board members, and downstream entities, for a minimum of 10 years. Records maintained must include but are not limited to training materials and training logs, documentation of exclusion checks, and dissemination of compliance program policies.

Offshore Subcontractor Reporting

My organization does not perform any work nor has any subcontractors that perform any work offshore that involves the receipt, processing, transferring, handling, storing, or accessing of protected health information (PHI) belonging to any Medicare Advantage beneficiaries.

If my organization uses an Offshore Subcontractor, a signed Offshore Contractor Attestation Form* linked below and included with this communication will be completed.

*Offshore Subcontracting Attestation Form

Attestation Authorization

I certify that the information above is true and correct to the best of my knowledge, and the above compliance program requirements have been met. In addition, my organization and I will furnish evidence of completion of the above to Delta Dental of Colorado upon request for monitoring and auditing purposes.

Organization Name:	Organization Representative Signature:
Contracted Dentist's Printed Name:	Contracted Dentist's Signature:
Title:	Date:
Email Address:	Phone Number:
Tax Identification Number:	Office Address 1:
Office Address 2:	Office Address 3:

If the attestation applies to more than three dental office locations, please attach a separate sheet listing all locations.

Please return completed document to your Provider Relations or DSO Representative.

*The training module made available by DDCO is an option of what can be used as your training module to meet the requirement; however, it's not the only option and does not have to be what you use to meet the requirement.

DELTA DENTAL

Offshore Subcontractor Disclosure and Attestation

The Centers for Medicaid and Medicare Services (CMS) require Medicare Advantage Organizations (MAOs) to notify CMS of MAO's and first-tier, downstream and/or related entities' (FDRs) offshore subcontractor activities.* As a contracted provider in the Delta Dental Medicare Advantage Network™, you are a FDR and in accordance with this regulation and your Delta Dental Medicare Advantage Network Addendum, you must complete and submit this required attestation to Delta Dental of Colorado within 10 calendar days if you are currently contracted with an offshore subcontractor. This is an ongoing obligation and this form must be completed immediately upon contracting with an offshore subcontractor in the future.

Please note: A separate form must be completed for each office location.

SECTION A: Dental Entity Information

Organization/Practice Name:	Tax Identification Number:
Email Address:	Physical Address (Include Suite):
City:	County:
State:	ZIP Code:

SECTION B: Offshore Subcontractor Information

Offshore Subcontractor Name:
Offshore Subcontractor Country(ies):
Offshore Subcontractor Address:
Offshore Contractor City, State, ZIP Code:
If multiple offshore locations, attach another sheet of paper with the full address of each offshore location, including the country, which will receive, process, transfer, handle, store or access Personal Health Information (PHI).
Describe Offshore Subcontractor Functions:
Proposed or Actual Effective Date of Offshore Subcontractor:

SECTION C: Precautions for Personal Health Information (PHI)

Description of the PHI that will be provided to the offshore entity (select all that apply):

- ☐ Names
- ☐ Ages
- ☐ Date of Birth
- ☐ Addresses
- ☐ Phone Number
- ☐ Full Social Security Numbers
- ☐ Partial Social Security Numbers
- ☐ Medicare HICN/MBI Numbers
- ☐ Delta Dental Member ID Numbers
- ☐ Claims history
- ☐ Diagnoses
- ☐ Medical/dental history
- ☐ Banking/financial information
- ☐ Other (specify):

Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives

Describe alternatives considered to avoid providing PHI and why each alternative was rejected

SECTION D: Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract

Offshore subcontracting arrangement has policies and procedures in place to ensure Medicare beneficiary PHI and other personal information remains secure

◯ Yes ◯ No

Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with the Dental Entity's contract with the offshore subcontractor

◯ Yes ◯ No

Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach

◯ Yes ◯ No

Offshore subcontracting arrangement includes all required Medicare Advantage plan language (e.g. records retention requirements, compliance with Medicare Part C and D requirements, etc.)

◯ Yes ◯ No

SECTION E: Attestation of Audit Requirements to Ensure Protection of PHI

Dental entity will conduct an annual audit of the offshore subcontractor

◯ Yes ◯ No

Audit results will be used by the organization to evaluate the continuation of its relationship with the offshore subcontractor

◯ Yes ◯ No

Dental entity agrees to share the offshore subcontractor's audit results with Delta Dental of Colorado upon request

◯ Yes ◯ No

SECTION F: Authorized Signature

By signing below, I attest that I have carefully reviewed the information provided and attest to its completeness and accuracy, and that I have the authority to fill out this form on behalf of the dental entity.

Printed Name of Authorized Representative:

Title of Authorized Representative:

Signature:

Date Signed (MM/DD/YYYY):

Please return the completed form to:
Email: profservices677@ddpco.com
Mail: Delta Dental of Colorado PO Box 5468 Denver, CO 85080-3000

*The Centers for Medicare and Medicaid Services (CMS) defines an offshore subcontractor as follows: "The term subcontractor refers to any entity or organization that a Medicare Advantage Organization or Part D sponsor contracts with to fulfill or help fulfill requirements in their Part C and/or Part D contracts. The term subcontractor includes all first-tier, downstream and/or related entities (FDRs) as defined by Medicare regulations. The term offshore refers to any country that is not within the United States or one of the United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico,and Virgin Islands). Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be either American-owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies."