STANISLAUS DENTAL FOUNDATION

APPLICATION CHECKLIST

Please review the following checklist and make sure your Dental Provider Application and Provider Agreement Form are complete, including any additional information that is required before mailing.

Checklist for Mailing

( ) Completed SDF Dental Provider Agreement

( ) Completed SDF Dental Provider Application

( ) Copy of Current California Dental License (*showing expiration date*)

( ) Copy of Proof of Malpractice Insurance Coverage (*showing coverage limits*)

Please forward all documentation listed above in an envelope addressed as shown below:

STANISLAUS DENTAL FOUNDATION
2401 E. Orangeburg Ave. Ste. 675-319
Modesto, CA 95355

IMPORTANT: Please **do not** send your fee schedule with this application. If you need to revise your accepted fees, please send them directly to the plan administrator:

STANISLAUS FOUNDATION FOR MEDICAL CARE
2339 St Paul's way
P.O. Box 576007
Modesto, CA 95357-6007

All fee schedules are considered confidential and will not be seen by any Stanislaus Foundation dentist or member of Stanislaus Dental Foundation's Board of Directors.

STANISLAUS DENTAL FOUNDATION
DENTAL PROVIDER APPLICATION

Confidential Document
Please Print or Type

_____ _____ _____
Provider's Name | California Dental License Number | Expiration Date
***Please attach copy of your Dental License**

_____ _____ _____
Specialty | Social Security Number | Date of Birth

Education

Institution_____ _____Graduation Date_____ Type of Degree ( ) DDS ( ) DMD

Special Training_____Graduation Date_____ _Degree ( ) Certificate ( ) Masters ( ) Doctorate

Additional dental training expending scope of practice_____

_____

Home Address

_____(_____)_____
Street number | City | Zip | Area Code -Telephone

Do you maintain malpractice (errors and omissions) coverage to at least the limit of $100,000/$300,000? ( ) Yes ( ) No
Carrier_____ Policy Number_____
*** Please attach copy of Insurance Coverage**
Does the same policy provide public liability coverage on the office premises to at least the limits of $100,000/$300,000? ( ) Yes ( ) No
If no:
Carrier_____ Policy Number_____
***Please attach copy of Insurance Coverage**

First Office Mailing Address

Employer Identification Number (EIN)_____

_____(_____)_____
P.O. Box or Street | Area Code - Telephone Number

_____(_____)_____
City | Zip | Area Code - Fax Number

Office Location (if different from mailing address)

_____
Street | City | Zip

If fees apply to other office locations, please list on the enclosed separate sheet the mailing and office addresses, telephone numbers, Employer Identification Numbers, ownership and insurance information .

Type of Practice

Each practicing dentist in your office must submit a separate application to Stanislaus Dental Foundation to be considered a participating member of the Stanislaus Dental Foundation.

( ) Individual ( ) Associate ( ) Group ( ) Partnership

If a group practice, please list the names of each of the dentists who are participants in the group practice. If an associate or partnership, please list the name(s) of your associate(s) or partner(s). Use a separate sheet if there are more than four.

Name_____California Dental License Number_____Expiration Date_____Speciality_____

Name_____California Dental License Number_____Expiration Date_____Specialty_____

Name_____California Dental License Number_____Expiration date_____Specialty_____

Name_____California Dental License Number_____Expiration Date_____Specialty_____

Do other providers in your practice routinely see your patients? ( ) Yes ( ) No

Office Hours
Monday_____Tuesday_____Wednesday_____Thursday_____
Friday_____Saturday_____Sunday_____

After Hours & Emergency Coverage
Do you have or can you be reached by:

Answering service ( ) Yes ( ) No Answering machine ( ) Yes ( ) No Pager system ( ) Yes ( ) No Cellular phone ( ) Yes ( ) No

Languages spoken by you or a member of your staff other than English (including sign language)_____

_____

1. Have you been charged or threatened with a charge for unprofessional conduct by any person at any time during the preceding five years? ( ) Yes ( ) No

2. Have you ever been convicted of a felony? ( ) Yes ( ) No

3. Has any committee of the State or Local Dental Association ever censured you with regard to professional ethics? ( ) Yes ( ) No

4. Have you been a party in any lawsuit, action or proceeding involving professional malpractice within the preceding five years? ( ) Yes ( ) No

5. Since you initially obtained your license to practice dentistry in the State of California, have you ever been required to appear before the California Board of Dental Examiners for disciplinary action? ( ) Yes ( ) No

6. Has any disciplinary action ever been taken against you, or is any such action presently pending or threatened, which resulted in or could result in any suspension or revocation of the license listed above or which resulted in or could result in any suspension or revocation of any hospital or staff privileges which you have been granted in any state? ( ) Yes ( ) No

If you answered "Yes" to any of the six questions above, please explain the circumstances involved on a separate sheet.

APPLICATION CERTIFICATION AND RELEASE

I hereby certify that the above information is complete, accurate and true and understand all information included in this application is strictly confidential.

Any information entered into this application which is subsequently found to be false could result in my immediate termination from membership with the Stanislaus Dental Foundation.

I hereby authorize the release to Stanislaus Dental Foundation true copies of historical, utilization, and credentialing data, information that may be obtained from individuals, universities, and other entities as provided upon my application. Further, I release from liability all those who in good faith and without malice, review, act on, or provide information regarding my competence, professional ethics, character, health status, and other qualifications for participation in the Stanislaus Dental Foundation.

_____ _____
Signature of Applicant Date

_____
Print Name of Applicant

STANISLAUS DENTAL FOUNDATION
DENTAL PROVIDER AGREEMENT

THIS AGREEMENT is made and entered into by and between the STANISLAUS DENTAL FOUNDATION, a California nonprofit corporation ("FOUNDATION"), and _____, a duly licensed provider of dental health care ("PROVIDER").

1. PROVIDER PANEL

a. Panel Participation. FOUNDATION contracts with dentists to maintain a FOUNDATION provider panel ("FOUNDATION Panel") for the purpose of making the professional services of these providers available under certain terms and conditions to third party payors of dental care costs ("Payors").

b. Panel Participant. PROVIDER agrees to participate on the FOUNDATION Panel and hereby authorizes and directs FOUNDATION to identify PROVIDER as a FOUNDATION Panel participant and to provide Payors with relevant information as may be necessary for this purpose.

2. PROVIDER SERVICES.

a. Dental Services. PROVIDER agrees to render appropriate and medically necessary dental services to any person, referred to herein as a "Patient," who is covered under an applicable benefit agreement of a Payor with which FOUNDATION has contracted, in accordance with generally accepted professional standards. This provision does not affect any right that PROVIDER may otherwise have to elect not to provide treatment to any Patient. FOUNDATION shall maintain the right to designate which Patients shall be served by PROVIDER, however, PROVIDER shall retain the right to request the reassignment of a Patient if the Patient unreasonably refuses to follow the advice of PROVIDER or otherwise manifests behavior, which is disruptive to PROVIDER's practice.

In the event that PROVIDER is unable to provide the required dental services, PROVIDER shall arrange with another FOUNDATION PANEL PROVIDER to provide the required dental services. If no other FOUNDATION PANEL PROVIDER is available or able to provide the dental services required, PROVIDER shall arrange for coverage through a Non-FOUNDATION PANEL PROVIDER, provided however, the Non-FOUNDATION PANEL PROVIDER agrees to be bound by all of the terms and conditions of this Agreement including the compensation provision set forth herein.

b. Referrals. Consistent with exercise of PROVIDER's best professional judgment, PROVIDER agrees to refer Patients, when necessary, according to FOUNDATION's referral and authorization policies as may be adopted from time to time by FOUNDATION's Board of Directors.

c. Peer Review. PROVIDER agrees to participate in peer review programs and procedures developed or adopted by FOUNDATION and to abide by peer review decisions, once the appeals process has been exhausted. All criteria and guidelines for such peer review shall be according to FOUNDATION's Utilization Review Procedures Manual, which shall be available for review by PROVIDER and PROVIDER shall, in all events, have a right to appeal from peer review decisions.

d. PROVIDER Qualifications. PROVIDER shall maintain a current license to practice dentistry in the State of California and a current DEA permit, if appropriate. PROVIDER shall notify FOUNDATION in writing within three (3) calendar days of the occurrence of any of the following events:

(1) PROVIDER'S license to practice dentistry is denied, revoked, restricted, suspended or voluntarily relinquished;

(2) PROVIDER learns or reasonably should know that he or she has become a defendant in any malpractice action or is required to pay damages in any such action by way of judgment or settlement.

(3) PROVIDER's professional liability coverage is reduced below the limits required by FOUNDATION, canceled, modified, or no longer in effect;

(4) PROVIDER becomes the subject of any disciplinary proceeding or action before the Board of Dental Examiners of the State of California;

(5) PROVIDER becomes incapacitated, as determined by the standards established by FOUNDATION;

(6) A change in PROVIDER's business address and or business phone number, tax identification number, State dental license number, DEA number, or Board status;

(7) The imposition of any sanctions against PROVIDER under the Medicare or Medi-Cal programs; or

(8) Any other situation which might materially affect PROVIDER's ability to carry out PROVIDER's duties and obligations under this Agreement.

(9) Participating Dentist Membership Applications will be accepted only from American Dental Association Active members.

3. COMPENSATION.

a. For services rendered to a Patient, PROVIDER agrees to accept as payment in full, the PROVIDER'S current approved fee listing on file with the contracted plan administrator. This fee listing will consist of the lowest fees usually received for each procedure. The fee listing must accompany participating membership application and may be updated as needed by the PROVIDER forwarding a copy of the listing to the contracted plan administrator. All fee listings will be maintained on a strictly confidential basis by the contracted plan administrator, and will at no time be seen by any member dentist or member of the Foundation Board of Directors.

b. Non-participating PROVIDER will be paid on a Table of Allowances.

c. When there is no fee on file for a particular procedure, the plan administrator will determine an appropriate allowance based on local charges for similar services.

d. Participating PROVIDER will be notified of the amount payable by the patient at the time of payment or, in the case of prior authorization, at the time of authorization.

e. Payment of services will be made directly to Participating PROVIDER. For non-participating PROVIDER, payment will be made to the patient.

f. Financial Responsibility of Patient. In the event PROVIDER is not paid within ninety (90) days after rendering service, PROVIDER shall have the right to bill the Patient for services rendered at PROVIDER's usual, customary and reasonable rates and not at the rate set forth on the reimbursement schedule of Payor's contract.

g. Co-Payments. In the event a co-payment is required from a Patient, PROVIDER shall collect such co-payment directly from Patient at the time of rendering the professional service.

h. Coordination of Benefits. It is the Patient's responsibility to disclose multiple insurance coverage. In the event a Patient has multiple insurance coverage and compensation hereunder amounted to less than PROVIDER's

usual, customary and reasonable charge for services rendered, PROVIDER shall be entitled to directly bill Patient or other responsible parties for appropriate additional amounts pursuant to existing coordination of benefit standards or pursuant to existing contracts with such other responsible parties.

4. ADMINISTRATION OF CLAIMS.

a. Administrator. FOUNDATION shall provide or contract for the provision of services reasonably necessary for the administration of claims hereunder.

b. Claims. PROVIDER shall submit claims in accordance with applicable claims administration procedures adopted by FOUNDATION and shall furnish sufficient information and billing data to allow the administrator to effectively administer payment in accordance with the terms hereof and those of the applicable benefit agreement.

5. RECORDS

a. Provider shall maintain and provide such information to FOUNDATION or the Payor such records of the services rendered to Patients as may be required by any fiscal intermediary, federal, state, or local governmental agency, or Plan.

b. Confidentiality. To the extent required by law, FOUNDATION and PROVIDER shall maintain confidentiality of dental records.

6. MODIFICATION AND ASSIGNMENT

a. Modification. This Agreement may be modified only in writing. Modification by FOUNDATION shall be effective thirty (30) days after giving PROVIDER written notice of the proposed modification unless PROVIDER shall within such thirty (30) day period notify FOUNDATION in writing of an objection to such modification.

b. Assignment. This Agreement is personal in nature and the rights or duties hereunder shall not be transferred, delegated or assigned by PROVIDER.

7. TERM AND TERMINATION.

a. Term. This Agreement shall be in effect for a period of one (1) year beginning from the date of execution by PROVIDER and shall automatically be renewed for one (1) periods until terminated in accordance with the provisions of this Section 7.

b. Termination. This Agreement may be terminated without cause by either party only upon ninety (90) days' written notice to the other or upon thirty (30) days' written notice if the party to whom notice is given has materially breached any provision hereof. FOUNDATION shall have the right to terminate this Agreement immediately upon written notice to PROVIDER upon the occurrence of any of the following events:

(1) PROVIDER's license to practice dentistry in the State of California is suspended or revoked;

(2) PROVIDER's professional liability coverage as required under this Agreement is no longer in effect;

(3) PROVIDER's death or incapacity. Incapacity shall be determined by the standards established by FOUNDATION Board of Directors;

(4) PROVIDER's institution of any bankruptcy, insolvency or receivership;

(5) PROVIDER's failure to comply with a program established by FOUNDATION, including but not limited to utilization and quality assurance issues; or

(6) PROVIDER fails to notify FOUNDATION in accordance with Section 2.d. of this Agreement.

c. Responsibilities After Termination. In the event PROVIDER commences dental treatment prior to the termination of this Agreement and that treatment continues beyond the date of termination, PROVIDER agrees to notify the Patient of termination of this Agreement and further agrees to accept payment in accordance with the applicable contract as payment in full for services covered by the applicable benefit agreement until the conclusion of the course of treatment or for thirty (30) days following termination of this Agreement, whichever comes first.

8. ELIGIBILITY

a. Unless otherwise provided for in an applicable Payor contract, the Payor shall be responsible for Patient eligibility determinations. This responsibility shall in no event obligate Payor for deductibles, co-insurance, exclusions or other limitations as may apply in accordance with the terms of an applicable benefit agreement.

9. INSURANCE.

a. Each party agrees to maintain adequate limits of liability for comprehensive general liability and professional liability insurance issued by a company licensed to conduct the business of insurance in the State of California. PROVIDER shall also maintain Worker's Compensation Insurance coverage for PROVIDER's employees. PROVIDER agrees to give FOUNDATION satisfactory evidence of such insurance or other coverage upon request.

10. PROFESSIONAL PRACTICE AND QUALITY.

a. PROVIDER and FOUNDATION acknowledge that PROVIDER shall remain in complete control of PROVIDER's professional practice and shall remain solely responsible for acts and decisions in rendering professional services. FOUNDATION shall at no time control or be responsible to any extent for the professional practice of PROVIDER or the quality of services delivered by PROVIDER.

11. NOTICES.

a. All notices and other communications given to a party hereunder shall be in writing and shall be deemed to have been duly given when delivered personally or within seventy-two (72) hours after being mailed first class, postage prepaid, to the address of that party set forth herein following the party's signature or to such other address as either of the parties hereto may from time to time designate in writing.

12. NON-EXCLUSIVITY.

a. PROVIDER is not obligated to participate solely on the FOUNDATION Panel or to obtain Payor contracts only through FOUNDATION and may participate in other alternative health care delivery programs at PROVIDER's sole discretion.

13. APPLICABLE LAW.

a. This Agreement shall be governed by the laws of the State of California.

14. CONTINUED ELIGIBILITY.

a. During the term of this Agreement and for any extensions of renewals, PROVIDER agrees to continue to meet the criteria for membership in effect at the time PROVIDER became a member of the FOUNDATION Panel.

15. INDEPENDENT CONTRACTOR.

a. The relationship of the parties to this Agreement is determined solely by the provisions of this Agreement. The parties do not intend to create any agency, partnership, join venture, trust or other relationship with duties or incidents different from those of parties to an arms-length contract.

16. BINDING AFFECT OF AGREEMENTS.

a. By executing this Agreement, PROVIDER appoints FOUNDATION as PROVIDER's attorney-in-fact, with authority to act on PROVIDER's behalf to enter into FOUNDATION Agreements with Payors, and agrees to be bound by all such agreements.

STANISLAUS DENTAL FOUNDATION
A California non-profit corporation

By _____
Signature of President

_____
Printed Name of President

Dated: _____

PROVIDER

By _____
Signature of Provider

_____
Printed Name of Provider

Dated: _____

OFFICE ADDRESS OF PROVIDER

Street: _____

City: _____

Phone: _____ Zip: _____

California License Number: _____