

PARTICIPATING PROVIDER APPLICATION

Please complete the following information and mail to:

Dental Direct 2600 South Road, Suite 44-202, Poughkeepsie, NY 12601 • (888) 972-7160

The following items must be included for application approval;
DEA License, Dental License, Medical Malpractice Insurance

dentaldirect
www.dentalplansdirect.com

PRACTICE INFORMATION *(*Information included in Directory Webpage Practice Profile)*

*Dental Office Name: _____

*Street Address: _____

*City: _____ State: _____ Zip: _____

*Telephone: _____ *Fax: _____

*Email address: _____

*Website URL: _____

Tax ID # (required): _____

National Provider ID (Corporate/Group, if applicable): _____

Office Manager/Contact Name: _____

OFFICE PROFILE DETAILS *(The below information is included in Directory Webpage Practice Profile to increase search visibility.)*

Hours of Operation:

- Monday _____
- Tuesday _____
- Wednesday _____
- Thursday _____
- Friday _____
- Saturday _____
- Sunday _____

Specialties:

- Endodontics
- Oral Surgery
- Orthodontics
- Periodontics
- Pedodontics
- Prosthodontics

Services:

- Cosmetic Dentistry
- Dental Implants
- General Dentistry
- Restorative Dentistry
- Teeth Whitening
- Veneer/Laminate
- In-Office Crowns

Language:

- English
- Spanish
- French
- Other _____

Healthcare Preferences Available:

- Evening Hours
- Weekend Appointments
- Specialists On Site
- Advanced Technology
- Sedation Available
- 3D Imaging
- ConeScan
- Paperless Environment

Insurance Participation:

- Name: _____
- Name: _____
- Name: _____
- Name: _____
- Name: _____
- Name: _____

if there are additional providers, then attach supplemental copies of information

PROVIDER INFORMATION (List each dentist you want to add on panel as a participating Dental Direct provider.)

First Name: _____ Last Name: _____

Specialty: General Dentist Pedodontist Periodontist Endodontist
 Oral Surgeon Orthodontist Prosthodontist

Degree: D.D.S. D.M.D.

State License #: _____ Expiration Date: _____

DEA #: _____ Expiration Date: _____

National Provider Identifier (NPI) _____ Expiration Date: _____

Dental School: _____ Graduation Year: _____

Additional Providers

First Name: _____ Last Name: _____

Specialty: General Dentist Pedodontist Periodontist Endodontist
 Oral Surgeon Orthodontist Prosthodontist

Degree: D.D.S. D.M.D.

State License #: _____ Expiration Date: _____

DEA #: _____ Expiration Date: _____

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State License #: _____ Expiration Date: _____

DEA #: _____ Expiration Date: _____

National Provider Identifier (NPI) _____ Expiration Date: _____

Dental School: _____ Graduation Year: _____

COPIES TO ATTACH FOR PARTICIPATING PANEL PROVIDER (*required)

DEA License* Dental License* Medical Malpractice Insurance*

Please complete the following information and mail to:

Dental Direct
2600 South Road, Suite 44-202
Poughkeepsie, NY 12601

Fax Application to: (800) 556-1750

General Dentist Fee Schedule

Dentists may add additional lab fees to discounted services with*

DIAGNOSTIC & PREVENTATIVE

Code	Fee
D0120 Periodic Oral Evaluation	15
D0140 Limited Oral Evaluation - Problem Focus	20
D0150 Comprehensive Oral Evaluation	25
D0210 Xrays – Complete Series	50
D0220 Xrays – Periapical – 1st Film	10
D0230 Xrays – Periapical – Each Additional	5
D0274 Bitewings – Four Films	20
D0330 Panoramic Film	55
D0470 Diagnostic Casts	30
D1110 *Prophylaxis – Adult Cleaning	45
D1120 *Prophylaxis – Child Cleaning	35
D1203 Fluoride	15
D1330 Oral Hygiene Instructions	5
D1351 Sealant – Per Tooth – No Age Limit	20

1 FREE CLEANING PER YEAR

*D1110, *D1120 (exam & x-ray can be charged in addition)

RESTORATIVE

Code	Fee
D2140 Amalgam – One Surface	45
D2150 Amalgam – Two Surfaces	65
D2160 Amalgam – Three Surfaces	75
D2161 Amalgam – Four Surfaces	95
D2330 Resin Based Composite – One Surface - Anterior	55
D2331 Resin Based Composite – Two Surfaces - Anterior	75
D2332 Resin Based Composite – Three Surfaces - Anterior	110
D2391 Resin Based Composite – One Surface - Posterior	75
D2392 Resin Based Composite – Two Surfaces - Posterior	100
D2393 Resin Based Composite – Three Surfaces - Posterior	135
D2394 Resin Based Composite – Four Surfaces - Posterior	165
D2750 * Crown – Porcelain Fused to High Noble Metal	750
D2752 * Crown – Porcelain Fused to Noble Metal	650
D2920 Recement Crown / Bridge	No Charge
D2950 Core Buildup – Including any Pins	100
D2951 Pin Retention - Per Tooth in Addition to Restoration	25
D2954 Prefabricated Post & Core	125
D2970 Provisional Crown	50

ENDODONTICS

Code	Fee
D3110 Pulpotomy (Excluding Final Restoration)	80
D3120 Pulp Cap Indirect	25
D3220 Therapeutic Pulpotomy (Excluding Final Restoration)	60
D3310 Root Canal – Anterior	375
D3320 Root Canal – Bicuspid	475
D3330 Root Canal – Molar	575

PERIODONTICS

Code	Fee
D4210 Gingivectomy Per Quad	450
D4211 Gingivectomy Per Tooth	200
D4341 Perio Scaling/Per Quadrant	70
D4381 Localized Delivery of Antimicrobial Agents Via a Controlled Release Vehicle into Diseased Crevicular Tissue - Per Tooth, By Report	50 Per Site
D4910 Perio Maintenance	90

PROSTHODONTICS - REMOVABLE

Code	Fee
D5110 *Complete Denture – Maxillary	700
D5120 *Complete Denture – Mandibular	700
D5130 *Immediate Denture – Maxillary	575
D5140 *Immediate Denture – Mandibular	575
D5213 *Maxillary Partial - Denture Bases (Including any Conventional Clasps, Rests or Teeth)	750
D5214 *Mandibular Partial - Denture Bases (Including any Conventional Clasps, Rests or Teeth)	750
D5410 Adjust Complete Denture – Maxillary	30
D5411 Adjust Complete Denture – Mandibular	30
D5520 *Replace Missing/Broken Teeth	50
D5630 *Repair/Replace Broken Clasp	70
D5650 *Add Tooth To Existing Partial Denture	65
D5660 *Add Clasp To Existing Partial Denture	70
D5730 *Reline Complete Maxillary Denture (Chairside)	150
D5731 *Reline Complete Mandibular Denture (Chairside)	150
D5740 *Reline Maxillary Partial Denture (Chairside)	150
D5741 *Reline Mandibular Partial Denture (Chairside)	150
D5750 *Reline Complete Maxillary Denture (Lab)	200
D5751 *Reline Complete Mandibular Denture (Lab)	200

PROSTHODONTICS - FIXED

Code	Fee
D6020 *Implant Abutment	575
D6010 Implant	825
D6059 *Implant Crown	900
D6190 Pre Surgical Index	175
D6242 *Pontic – Porcelain Fused to Noble Metal	550
D6752 *Abutment – Porcelain Fused to Noble Metal	550

ORAL SURGERY

Code	Fee
D7140 Ext Erupted Tooth/Exposed Root	75
D7210 Surgical Extraction	175
D7220 Removal Impacted Tooth – Soft Tissue	130
D7230 Removal Impacted Tooth – Partial Bony	170
D7240 Removal Impacted Tooth – Completely Bony	220
D7250 Surgical Removal of Residual Root	110
D7288 Brush Biopsy	175
D7310 Alveoloplasty in Conjunction w/Ext - Per Quad	105
D7320 Alveoloplasty Not in Conjunction w/Ext - Per Quad	150
D7510 Incision & Drainage of Abscess	80

Dental Specialist Fee Schedule

*Dentists may add additional lab fees to discounted services with**

ORAL SURGERY & PERIODONTICS

Code	Fee
D3410 Apico Anterior – First Root	400
D3421 Apico Bicuspid – First Root	500
D3430 Retrograde Filling – 1st Root	150
D4210 Gingivectomy – Per Quad	600
D4249 Crown Lengthening	550
D4260 Osseous Surgery - Per Quad	750
D4263 Bone Graft – Per Site	400
D4273 Root Coverage – Per Tooth	800
D4274 Distal Wedge – Per Site	500
D4321 *Splinting	400
D4341 Scaling & Root Planning - Per Quad	175
D4910 Perio Maintenance	100
D6010 Implant	1,250
D6020 *Implant Abutment	600
D6059 *Implant Crown	850
D7140 Simple Extraction	150
D7210 Surgical Extraction	185
D7220 Surgical Extraction – Soft Impaction	200
D7230 Surgical Extraction – Partial Bony	250
D7240 Surgical Extraction - Full Bony Impaction	275
D7250 Surgical Extraction – Root Tip	185
D7288 Brush Biopsy	200
D7310 Alveoloplasty in Conjunction w/Ext - Per Quad	155
D7320 Alveoloplasty Not in Conjunction w/Ext - Per Quad	200
D7410 Biopsy - Excision of Benign Lesion up to 1.25 cm	400
D7510 Incise And Drain Intraoral	200
D7951 Sinus Lift – Window	1,500
D7951 Sinus Lift – Osteotomy/Per Site	300
D7960 Frenectomy	375
D9310 Specialist Consultation	125

ENDODONTIST

Code	Fee
D3310 Root Canal – Anterior	600
D3320 Root Canal – Bicuspid	700
D3330 Root Canal – Molar	750
D3410 Apico Anterior – First Root	400
D3421 Apico Bicuspid – First Root	500
D3425 Apico Molar – First Root	600
D3426 Each Additional Root	200
D3430 Retrograde Filling – 1st Root	150

MISCELLANEOUS

Code	Fee
D2962 *Laminates / Veneers	750
D4321 *Splinting	400
D9110 Palliative Treatment Dental Pain - Minor Procedure	35
D9215 Local Anesthesia	10
D9940 *Niteguard	350
D9951 Occlusal Adjustment-Limited	50
In Office Whitening System (i.e. Zoom)	475

ORTHODONTICS

25% Discount / UCR Fees

PEDODONTICS

25% Discount / UCR Fees

*Any Service not listed on Discounted Fee Schedule,
please refer to office private fees.*

*Patients Pay at Time of Service
No Claims, No Waiting, No Limitations*

dentaldirect
DISCOUNT DENTAL BENEFITS PLAN

(888) 972-7160 Ext. 4
www.dentalplansdirect.com

Dental Direct Discount Membership Program

Participating Dentist Agreement / Terms & Conditions

This Agreement ("Agreement") is entered into between the undersigned dentist ("Participating Dentist") and Dental Direct Benefits, by and on behalf of itself and its subsidiaries and affiliates ("Dental Direct Benefits").

I. General Provisions

1. Participating Dentist (General Dentist or Specialist) or Participating Group Practice agrees to provide Dental Services to Members and to provide such services in the same manner in which, and with the same availability as, Participating Dentist provides services to his or her other patients. Participating Dentist agrees to provide Dental Services without discrimination against any Members on the basis of participation in the Discount Membership Program, source of payment, age, sex, ethnicity, religion, sexual preference, health status or disability.
2. Participating Dentist represents and warrants that he or she is licensed to practice dentistry pursuant to the laws where he or she is practicing dentistry. Participating Dentist also represents and warrants that his or her license to practice dentistry and DEA registration, if applicable, are not suspended or revoked. Participating Dentist agrees that he or she will promptly notify Dental Direct Benefits in writing should either such license or registration be revoked, restricted, suspended or otherwise subject to disciplinary action by any government agency. Participating Dentist authorizes Dental Direct Benefits to obtain information concerning the undersigned's professional qualifications as well as to inquire within National Practitioner Data Bank about the undersigned's practice.
3. For purposes of this Agreement, "Dental Services" means a dental service or supply for which a benefit may be payable under the terms of a Discount Membership Program. "Discount Membership Program" means a group or individual dental care program that is administered by a third party partner. "Member" means an individual entitled to the Discount Membership Program.
4. Dental Direct Benefits may contract with persons or entities (including, without limitation, Dental Direct Benefits subsidiary or affiliated organizations, self-administered or self-funded programs providing dental care benefits, employers or insurers wishing to utilize the services of Dental Direct Benefits dental network) incorporating the terms and conditions of this Agreement. It is agreed that the other entity will succeed to all of Dental Direct Benefit's rights and obligations under this Agreement.
5. All Participating Dentists in the Discount Membership Program agree to accept as payment in full for Dental Services the amount shown in the attached assigned fee schedule (the "Fee Amount").
6. Dental Direct Benefits shall have no obligation to Participating Dentist for any claims for Reimbursement Amounts not paid by or on behalf of a self-funded group plan sponsor for which Dental Direct Benefits administers a Discount Membership Program. Dental Direct Billing reserves the right to change Reimbursement Amounts at any time upon notice to a Participating Dentist.
7. Members are responsible for all Dental Services that are not covered under the Discount Membership Program; Members are also responsible for all deductibles, co-payments and coinsurance amounts required under the Discount Membership Program. Participating Dentist agrees to charge and collect any applicable co-payments, coinsurance and/or deductible amounts as may be required.
8. Participating Dentist warrants that he or she has and shall maintain professional liability and comprehensive general liability insurance in amounts reasonable and customary for the Participating Dentist's location and specialty, at his or her sole cost and expense. Participating Dentist agrees to notify Dental Direct Benefits immediately of any termination or restriction of such coverage. Participating Dentist shall produce certificates of insurance.
9. Participating Dentist shall keep accurate and current dental files and records for each Member who is a patient. Participating Dentist agrees to comply with all applicable laws and regulations regarding the privacy and confidentiality of such records. Dental Direct Benefits may upon request with appropriate releases inspect and receive copies of dental records of Members without restriction. Participating Dentist shall make available such records to appropriate state and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating grievances or complaints.
10. Except as provided herein, neither Participating Dentist nor Dental Direct Benefits may use the other party's symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of that party. The Participating Dental Direct Discount Membership Program Dentist agrees to have his or her name, specialty, office address, office telephone number and office hours listed in the Dental Direct Benefits dental directory of contracted dentists.
11. Participating Dentist agrees that when Dental Direct Benefits contracts with other persons or entities for use of Participating Dentist's services under this Agreement. Participating Dentist will provide services to Members of that other entity in accordance with the terms of this Agreement. In all events, however, Participating Dentist shall look for payment only to the particular entity that covers the particular services for which Participating Dentist seeks to be compensated (except for applicable deductibles, copayments or other obligations of Members).
12. Participating Dentist agrees to Dental Direct Benefit's periodic review of utilization, quality of care and peer review.
13. The parties agree to keep the confidential and proprietary information or trade secrets of each other in trust and confidence and agree that such information shall be used for the purposes contemplated in this Agreement. Without limiting the generality of the foregoing, it is agreed that all compensation arrangements between the parties and the identities of Members shall specifically be considered proprietary and confidential.

II. Term and Termination

1. The term of this agreement shall begin on the Effective Date listed on the signature page of this Agreement and shall continue in effect until terminated by either party pursuant to the terms of this Agreement.
2. This Agreement may be terminated (i) without cause by either party by giving the other party thirty (30) days prior written notice, or (ii) immediately by Dental Direct Benefits if Participating Dentist's license(s) is/are revoked, suspended or restricted or if his or her professional liability insurance is terminated or restricted, or (iii) immediately by Dental Direct Benefits upon the death or disability of Participating Dentists.
3. If this Agreement is terminated, each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to termination, and Participating Dentist shall continue to provide Dental Services under the terms of this Agreement as if it had not been terminated for all courses of treatment of Members that began prior to the termination of this Agreement until such treatment is completed.

III. Dispute Resolution

1. Dental Direct Billing and Participating Dentist agree to meet and confer in good faith to resolve any problems or disputes that may arise.
2. In the event that any problem or dispute arising under this Agreement and/or concerning the terms of this Agreement is not satisfactorily resolved pursuant to Section 1 above, Dental Direct Benefits and Participating Dentist will arbitrate such problem or dispute. Such arbitration shall be initiated by either party making a written demand for arbitration to the other party. The arbitration will be conducted by the American Arbitration Association under the Commercial Rules of the American Arbitration Association, unless otherwise mutually agreed in writing by Dental Direct Benefits and Participating Dentist. Participating Dentist and Dental Direct Billing agree that the arbitration results shall be binding on both parties in any subsequent litigation or dispute.

IV. Miscellaneous

1. Participating Dentist shall be solely responsible to Members for the method or means by which Participating Dentist renders dental treatment or service to Members. Participating Dentist shall be solely responsible for any acts or omissions relating to the diagnosis and treatment of Members. Nothing herein shall be construed as granting Dental Direct Benefits the right to engage in the practice of dentistry.
2. The parties are independent contractors, and nothing in this Agreement is intended to create nor shall it be construed to create any employment, agency, joint venture or partnership relationship between the parties. Dental Direct Benefits shall have no dominion or control over Participating Dentist, the dentist-patient relationship, participating Dentist's personnel or facilities, or Participating Dentist's services.
3. If any portion of this Agreement is found to be void or illegal, the validity or enforceability of any other portion shall not be affected. This Agreement shall be governed by the laws of the state of New York. Dental Direct Discount Membership Program
4. No waiver or any breach, privilege or provision hereunder shall be construed as a waiver of any other breach hereunder.
5. Any notice provided for in this Agreement shall be in writing, hand-delivered, mailed by certified mail, or sent by a nationally recognized delivery service as follows:

If to Dental Direct Benefits: To the address Shown on the Signature Page of this Agreement

If to Participating Provider: To the first address listed at the end of this Agreement

6. This Agreement constitutes the entire agreement between the parties as to the subject matter hereof. This Agreement may be amended at any time during its term upon thirty (30) days' prior written notice to Participating Dentist from Dental Direct Benefits.

SIGNATURE

Please sign and date below that you have read and agree to the terms provided in the Participating Dentist Agreement.

Participating Dentist (type or print name)

Signature

Date

Dental Direct Benefits