SOUTHWEST
PREFERRED
DENTAL
ORGANIZATION

PROVIDER AGREEMENT

PROVIDER PROFILE
OFFICE PROFILE

Southwest Preferred Dental Organization, Inc.
3625 North 16th Street, Suite 206 Phoenix, AZ 85016

This Provider Agreement made and entered into the _____ day of _____, 20_____, by and between _____ hereinafter referred to as "Dentist/Provider" and Southwest Preferred Dental Organization, Inc., a preferred provider organization, hereinafter referred to as "Plan".

Plan and Dentist/Provider agree to the following:

A. Plan has organized a dental network to provide dental care and related benefits for the individuals, employees and eligible dependents of said individuals and employees (hereinafter shall be referred to as Member (s). Members covered by this Provider Agreement for which the Dentist/Provider is responsible include patients of record or persons listed on an eligible roster of the Plan or Participating Group in which the Dentist/Provider is participating.

B. Each of Participating Plans and Groups represented by Plan has entered into Plan Agreements with Plan by the terms of which the Plan has agreed to arrange dental care for such Members in exchange for periodic payments by such individuals or groups.

C. All such Plan Agreements with Participating Plans and Groups shall specify the Member's dental benefits and covered services and shall be included within the terms and conditions of this Provider Agreement.

It is specifically understood by the parties that the said Agreements contain varying provisions, and also provide that they may be modified prospectively from time to time. Now, therefore, in consideration of the mutual covenants herein contained and for other good and valuable consideration, it is agreed as follows:

RENDITION OF CARE:

1. Dentist/Provider (s) listed as undersigned and/or on Attachment 1 "Participating Dentist (s)" are included in this Provider Agreement.

2. Dentist/Provider agrees to render necessary dental services to each of the Members covered by Plan Agreement. Such rendition of services shall occur during his/her regular office hours, subject to prior appointments, provided, however, that Dentist/Provider shall have the right within the framework of professional ethics to reject any patient seeking his/her professional services.

ELIGILIBILTY:

3. All determinations as to the eligibility of any person for benefits under a Plan Agreement, or the standing of any person with respect to membership in any group entitled to benefits under a Plan Agreement shall be determined by the group and the Plan before the Dentist/Provider renders any dental services. Dentist/Provider will make telephone contact with a representative designated by the Plan, before delivering service to Members to confirm current membership and subscriber identification number.

FEES DUE DIRECTLY FROM MEMBER:

4. Dentist/Provider will not charge the Member for services covered by the Plan Agreement between the Member and Plan or between the Member and Participating Group except for coinsurance, copayments and deductibles that are applicable.

5. It is also understood and agreed that cases will arise where Dentist/Provider will perform dental services for Members, which services exceed benefit limitations or are not covered by the Plan Agreement then in force between the Member and the Plan or between the Member and the Participating Group. In such cases, Dentist/Provider agrees to look solely to the Member for payment of such services. Payment for such services shall be billed by Dentist/Provider at a rate not in excess of Dentist/Provider's usual and customary fee, less any amount paid by the group or such other insurance or other benefits covering said patient.

SUBSTITUTE – DENTIST

6. When the Dentist/Provider is on vacation or is to be absent for any extended period, Dentist/Provider shall provide a substitute dentist. Compensation to the substitute dentist in excess of the compensation otherwise payable under this Provider Agreement is the responsibility of the Dentist/Provider.

USE OF DENTIST/PROVIDER NAME

7. Dentist/Provider understands and consents to the inclusion of his/her name in Plan's or group's Provider Directories.

PARTICIPATING PLANS & GROUPS

8. The Participating Plans & Groups covered by this Provider Agreement are listed in Attachment 2 to this Provider Agreement. Such list may be modified from time to time. Dentist/Provider will be notified of any modification.

CHANGE IN CONTRACT TERMS AND BENEFITS WITH GROUPS AND MEMBERS

9. It is specifically understood that the benefits, terms and conditions of the various Plan Agreements between the Participating Groups and Plan may be changed from time to time during the term of this Provider Agreement. Plan agrees to notify Dentist/Provider in writing of the nature of such changes to the extent such changes affect the terms of this Provider Agreement. Unless, within ten (10) days after receipt of such notification, Dentist/Provider notifies Plan in writing that he/she declines to provide dental services to the group (s) involved and Members in accordance with the changed Plan Agreements, Dentist/Provider agrees to continue to perform dental services under the modified Plan Agreements, and this Provider Agreement shall be deemed amended accordingly.

STANDARD OF CARE

10. Dentist/Provider agrees that he/she shall perform his/her obligations under this Provider Agreement in accordance with high standards of competence, care and concern for the welfare and needs of the Members of Participating Groups and their dependents and in accordance with the "principles of ethics" of the American Dental Association and the Dental Practice Act of the State of Arizona or Nevada. It is understood that the inclusion of Dentist/Provider on the panel of the Plan or on one of the Plan's Participating Groups is not a recommendation of Dentist/Provider by the group or Plan.

NON – EXCLUSIVE

11. This Provider Agreement is not exclusive in any respect. Plan and each Participating Group and the Members of the Plan and such Groups are entitled to enter into similar agreements with other parties, or with other dentists. Dentist/Provider is free to enter into similar agreements with other parties, or with other groups not represented by Plan

DENTIST – PATIENT RELATIONSHIP

12. Dentist/Provider shall maintain the dentist-patient relationship with Members of Participating Groups, and shall be solely responsible to the patient for dental advice and treatment. It is expressly agreed between the parties that the Dentist/Provider is an independent contractor and that neither group nor Plan shall have any dominion or control over the Dentist's/Provider's practice, the dentist-patient relationship, his/her personnel or facilities.

MALPRACTICE

13. Dentist/Provider agrees to carry malpractice insurance in an amount not less than $1,000,000 per person or $3,000,000 per incident. Dentist/Provider will instruct Professional Liability Insurer to notify the Plan of termination of such coverage within ten (10) days of termination. Plan shall be notified in the event of policy changes, including but not limited to policy number, dollar coverage amount, and term of coverage and claim history.

NOTICE TO MEMBERS OF TERMINATION OF AGREEMENT

14. In the event that this Provider Agreement is terminated by either party, in accordance with the procedures set forth herein, Dentist/Provider agrees that at the time the patient seeks an appointment, he/she will notify Member prior to giving service that the Agreement is no longer in effect. In the event such notice is not given to the patient, Dentist/Provider agrees to accept payment for his/her services at a rate no more than set forth in the schedules attached hereto.

ASSIGNABILITY OF AGREEMENT

15. This Provider Agreement, being intended to secure the personal services of Dentist/Provider and dentists associated with Dentist/Provider, shall not be assigned or transferred without written consent of the Plan.

COMPENSATION TO DENTIST/PROVIDER

16. Dentist/Provider understands that there is no capitation involved in the Plan's dental program. Dentist/Provider further agrees and understands that the total reimbursement shall not exceed the fee schedules listed in Attachment 2 and made part of this Agreement. Dentist/Provider will be notified of changes to fee schedules and will have ten (10) days to request changes. Failure to request changes in the allowed time will be considered acceptance.

17. Unless delegated by Plan, Plan shall pay or arrange to pay Dentist/Provider for covered services rendered to members. Dentists/Providers shall bill Plan or, if designated by Plan, the Participating Group for all covered services related to Member by submitting bills to Plan or, if designated, the Participating Group. Plan shall inform Dentist/Provider as to Participating Group billing address if applicable by separate letter.

UTILIZATION AND QUALITY CONTROL

18. The Plan has organized a Quality Assurance and Utilization Review process through which dental care can be monitored on a continuing basis. A Review Committee compromised of dentists will review patient evaluations, diagnosis, treatment and follow-up care. This will be accomplished by the committee's comparison of Dentist's/Provider's dental care with standardized norms and criteria. All information gathered and discussions held in this process will be kept confidential amongst Plan employees, Plan Dental Director and Review Committees and not for general release.

Dentist/Provider will be informed about their dental care that does not conform to the Plan's standardized norms. Dentist/Provider will then be required to either follow the recommendations of the involved committee or demonstrate to that committee the appropriateness of their individual dental care. Dentists/Providers will use their best effort in delivering quality dental care in the most cost effective manner possible.

DURATION OF AGREEMENT

19. Dentist/Provider participation in this Provider Agreement shall initially be for one (1) year. Thereafter, either party may unilaterally terminate this Provider Agreement without cause, by giving sixty (60) days written notice mailed by registered or prepaid certified mail to the last known address of the other party. Termination shall be effective on the first day of the month following the completion of the sixty (60) day notice. Such termination shall have no effect upon the rights and obligations of the parties arising out of any transaction occurring prior to the effective date of such termination and any continuing obligations after the termination as set forth herein. Suspension or termination of Dentist/Provider license or failure to adhere to Plan's utilization and quality control process may result in immediate termination for cause of this Provider Agreement at any time.

20. If this Provider Agreement is terminated, Dentist/Provider will complete all treatment in progress and forward copies of the covered person's records and duplicate x-rays and study models to a new Dentist/Provider within thirty (30) days after the completion of the treatment in progress.

OPERATIONS, POLICIES, AND PROCEDURES

21. The operations, policies and procedures are contained in the Plan Guidebook. The contents of the Plan Guidebook are considered an addendum to this Provider Agreement. The Plan Guidebook will be updated periodically throughout the year. If you disagree with any part of the Plan Guidebook or subsequent update, you must notify the Plan within 10 days, otherwise it will be deemed as accepted.

22. The contents of the Provider Profile (Attachment 3) and Office Profile (Attachment 4) are considered an addendum to this Provider Agreement.

Check One: Corporation _____ Partnership _____ Proprietorship _____ Other _____

IF SIGNING AS AN INDIVIDUAL PRACTITIONER

By _____
(Dentist's/Provider's Signature)

_____
(Dentist's/Provider's Name – Please Print)

Date _____

_____
(Name of Individual Practice – Please Print)

SS# _____ TAX ID# _____

STATE LICENSE # _____

IF SIGNING ON BEHALF OF A GROUP (Multiple Practitioners)

By _____
(Signature of person authorized to bind Group-all practitioners listed)

_____
(Name/Title of Above – Please Print)

Date _____

_____
(Name of Group or Corporation – Please Print)

SS# _____ TAX ID# _____

STATE LICENSE # _____

If ownership is a corporation, list the address of the corporation and contact person:

Address:_____

Contact Name: _____

Phone Number: _____

FOR SPDO USE ONLY

ACCEPTANCE

By _____ Title _____
(SPDO Authorized Signature)

_____ Date _____
(Print Name)

ATTACHMENT 1

PARTICIPATING DENTIST (s)

List addresses and names of Providers/Dentists at each location that participate under this agreement. Only those listed below will be included in the Provider Directory of the Participating Plan or Group.

Location 1:

_____

_____
City State Zip Code

Phone: _____ Fax: _____

Participating Dentist (s): Specialty:

_____ _____

_____ _____

_____ _____

Location 2:

_____

_____
City State Zip Code

Phone: _____ Fax: _____

Participating Dentist (s): Specialty:

_____ _____

_____ _____

_____ _____

Location 3:

_____

_____
City State Zip Code

Phone: _____ Fax: _____

Participating Dentist (s): Specialty:

_____ _____

_____ _____

_____ _____

ATTACHMENT 2

FEE SCHEDULES

Fee Schedules

1. SecureCare Dental

   The Copay Plan, PPO Plan, SecureFlex Plan, & Indemnity Plan
   - SPDO/SecureCare Dental Fee Schedule

ATTACHMENT 3

SPDO PROVIDER PROFILE

Complete for Each Dentist

Provider Name _____

Office Name _____

Office Address _____
City State Zip Code

E-mail Address _____ **Office Website Address**_____

Date of Birth _____ **Social Security Number** _____-_____-_____

A. Credentials

1. Dental School_____ Year Grad. _____

2. Years in Practice _____ License # _____ A.D.A. Member ? _____

3. DEA License # _____ A.D.A. # _____

B. How long have you practiced at this location? _____

C. Dentist treatment hours at this location

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

D. Are these current hours of treatment? Yes No

Please list names and locations of practices you've practiced at for the past 5 years.

	NAME OF PRACTICE	LOCATION	DATES
Current:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

If currently working at another practice, do you plan on continuing to work there after the date of this application? **Yes No**

E. Board Profile (If answer yes to questions C3-5, list in comments below.)

1. Board Eligible _____ Date _____ No. _____
2. Board Certified _____Date _____ No. _____
3. Malpractice Incidents within the last five (5) years? **Yes No**

4. Has your dental license issued from any state been suspended or revoked within the last five (5) years? **Yes** **No**

5. Has any disciplinary action has been taken against you by any State Board of Dentistry within the past five (5) years? **Yes** **No**

Comments for Questions C 3 – 5

_____

_____

_____

F. Insurance

1. Professional Liability Insurance Company_____

_____

2. Policy # _____ Expiration Date _____

3. Coverage Amount $ _____

G. Additional Locations this Dentist is Practicing at:

1) _____

2) _____

3) _____

4) _____

H. Please list any languages other than English that are spoken by the Dentist.

_____

_____

I. Procedure Profile

Services the **Dentist listed on the first page of Provider Profile** routinely performs

		YES	NO
1.	**Periodontic**		
a.	Scaling and Root Planing	_____	_____
b.	Osseous Surgery	_____	_____
2.	**Crowns/Bridges/Dentures**		
a.	Fixed Crown and Bridge	_____	_____
	Type of Metal Offered: (check all that apply)		
	(Crown) _____ Base _____ Noble _____ High Noble		
	(Bridge) _____ Base _____ Noble _____ High Noble		
b.	Removable Partial and Full Dentures	_____	_____

			YES	NO
3.	**Endodontics**			
a.	Single Canal		_____	_____
b.	Two Canals	(uncomplicated)	_____	_____
c.	Three Canals	(uncomplicated)	_____	_____
d.	Four Canals	(uncomplicated)	_____	_____

(If you check no and are in a multi-doctor practice, will you refer to another general dentist within the practice to do the above procedure(s)?) _____ _____

4.	**Oral Surgery**			
a.	7140	Simple Extractions	_____	_____
b.	7210	Surgical Extractions erupted tooth	_____	_____
h.	9220	General Anesthesia	_____	_____
i.	9240	IV Sedation	_____	_____
j.		Nitrous Oxide	_____	_____

(If you check no and are in a multi-doctor practice, will you refer to another general dentist within the practice to do the above procedure(s)?) _____ _____

5. Pediatric Dentistry

a. Does this office perform most services needed by children? If no, please explain under "Comments." _____ _____

b. List minimum age of children that you see: _____

Comments:

_____

_____

_____

GENERAL RELEASE OF INFORMATION AUTHORIZATION

I have applied to Southwest Preferred Dental Organization (SPDO) for eligibility as a Plan Provider. I hereby authorize SPDO, its representatives, and Designees to consult with the administration and members of the staffs of institutions, professional licensing bodies, professional liability insurance carriers and professional organizations with which I have been associated and with others who may have information bearing on my professional competence, character and ethical qualifications. I hereby consent to the inspection by SPDO, its representative and Designees of all documents and information that may be material to an evaluation of my professional qualifications and competence.

By signing this authorization, I release from liability all representatives or Designees of SPDO, as well as all representatives of institutions, professional licensing bodies, professional organizations for their acts performed in good faith and without malice in connection with both the exchange of information as consented to above, as well as in connection with evaluating my application, my credentials and my qualifications.

A photocopy of this authorization is to be accepted with the same authority as this original.

_____

Signature

_____

Print Name

_____

Name of Practice

_____

Date

ATTACHMENT 4

SPDO OFFICE PROFILE

Complete for Each Location

A. **Name of Practice** _____

B. **Practice Address** _____

_____
City State Zip Code

Office E-mail Address _____ **Website Address** _____

Telephone Number (____) _____ **Fax Number** (____) _____

C. **Cross Streets** _____

D. **Mailing Address** _____

E. **Is this a newly constructed practice? Yes No**

F. **Hours of Operation including extended hours**

Mon: _____ Tue: _____ Wed: _____

Thurs: _____ Fri: _____ Sat: _____ Sun: _____

G. **List the minimum age of children you will see:** _____ **yrs. old**

H. **Principal Owner and Associates** (List all those who will be treating SPDO patients)
Please complete the enclosed SPDO Provider Profile for **each participating provider**.

	Name (First and Last)	Specialty	License Number	Expiration Date
Owner				
Owner				
Owner				
Associate				
Associate				
Associate				

How long has this practice been owned by the above listed owner(s)?_____

If this is a new practice, do you have an existing patient base?_____

I. **Who Performs Hygiene: (circle one) F/T Hygienist P/T Hygienist Dentist**
Name of Hygienist (s)_____

J. **Access to Care**

Next available Hygiene appointment _____ week(s).
Next available New patient appointment _____ week(s).
Is prophy preformed during the new patient appointment? **Yes** **No**

K. Emergency Care: Can a patient w/an emergency be seen within 24 hrs? Yes No

If no, what is your average time and what arrangements are made to take care of emergencies? _____

_____

L. OSHA Regulations: Are you in compliance with OSHA Regulations? **Yes No**

M. Please list any languages other than English spoken in the office _____

_____

N. Contact Person

1. Office Manager _____ Telephone (_____) _____

O. Treatment Hours

	Dentist (s)	Hygienist (s)		Dentist (s)	Hygienist (s)
Monday	_____	_____	Friday	_____	_____
Tuesday	_____	_____	Saturday	_____	_____
Wednesday	_____	_____	Sunday	_____	_____
Thursday	_____	_____			

P. Facilities

1. Is the office accessible to the handicapped? **Yes No**

Q. Office Billing

1. Does your office act as a central source for patient billing? _____
   If no, please list name and location of company used for patient billing.
   _____

2. What Dental Software does your office use? _____
   (i.e. – Softdent/Dentrix/Eaglesoft/Practice Works)

3. Does your office submit claims electronically? **Yes No**
   If "Yes", do you submit claims using your dental software? **Yes No**
   If you do not submit through your software, how do you submit electronically?
   _____
   Do you intend to submit claims electronically in the future? **Yes No**
   If "Yes", when? _____