# DELTA DENTAL OF IOWA
# PROFESSIONAL APPLICATION & CREDENTIALING FORM

Delta Dental of Iowa (DDIA) is dedicated to improving the health and smiles of the people we serve. Part of that commitment is meeting the credentialing standards set by Delta Dental Plans Association, State and Federal Government Regulations, and Group Purchasers of dental benefits. To meet this requirement of participation with DDIA, please complete this credentialing form and return with all required documents by email, mail, or fax to:

**Email:** credentialing@deltadentalia.com
**Mail:** Delta Dental of Iowa, 9000 Northpark Dr., Johnston, IA 50131, ATTN: Provider Relations
**Fax:** (515) 261-5608

Questions can be sent to credentialing@deltadentalia.com

Use the checklist below to ensure that you have included all necessary information before submitting to Delta Dental.

- ☐ **Complete and submit** all required and applicable fields of the credentialing form, with signature, including:
  - Explanation of any gaps in work history
  - Please provide an explanation in the space provided to any YES responses to the QUALITY FOCUSED QUESTIONS
- ☐ A copy of current professional liability insurance information that includes carrier name, covered dentist's name, policy number, limits (per occurrence and aggregate), and coverage period. Each dentist shall maintain minimal malpractice policy limits of $1,000,000 per claim and $3,000,000 aggregate.
- ☐ A copy of current Drug Enforcement Administration (DEA) registration, if applicable
- ☐ A copy of current Iowa Controlled Substance Act (CSA) registration, if applicable
- ☐ A copy of specialty certification, if applicable
- ☐ Sign and date applicable provider agreements
- ☐ For a new business, a completed W-9 for each office location
- ☐ For a new business, complete an Ownership & Control Disclosure Form. Make sure each page is completed. Signature page must be signed by owner or managing employee.

DELTA DENTAL®

## Confidentiality Statement

Delta Dental of Iowa maintains all credentialing and re-credentialing information in a confidential manner and strictly enforces provisions designed to safeguard information and ensure confidentiality.

## Practitioners Right to Review

As an applicant applying for and credentialing within the Delta Dental of Iowa (DDIA) network, you are entitled to specific rights. Our established processes are in place to facilitate your access to these rights.

Your rights include:

- The right to review information we have obtained from outside verification sources (e.g., Malpractice carriers, board certification and licensing organizations) that are not peer-review protected information.
- The ability to review and correct erroneous information.
- The right to request information on the status of your application.

For inquiries about the mentioned processes, kindly reach out to the Credentialing Coordinators at DDIA via the provided phone number or email address.

- Phone number – 1-800-544-0718
- Email – Provrelations@deltadentalia.com

If you are correcting information that has been submitted, you have thirty (30) calendar days from your application date to correct that information. We will need the corrected information sent to us in writing, preferably by email. The email address for submitting those corrections is: Credentialing@ deltadentalia.com.

If you need information on the status of your application, you can contact the DDIA Credentialing Coordinators at Provrelations@deltadentalia.com. DDIA will respond to you within five (5) business days by email with information as to what stage your application is in and if we need additional information or assistance from you and how to contact us.

## PROVIDER INFORMATION

| Name (First) (Middle) (Last) | Other Known Names(s) (i.e. maiden name, nickname) |
|---|---|
| Effective Date: (Will use received date if left blank) | Are you an Iowa Medicaid Provider? ☐ YES ☐ NO *See note below.* |

| Individual NPI (Type 1) *Required* | Date of Birth *Required* | Social Security Number *Required* | Gender ☐ M ☐ F ☐ Prefer not to disclose |
|---|---|---|---|

Race / Ethnicity: Choose one ☐ *I consent to display on the Provider Directory*

☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ Hispanic or Latino ☐ White ☐ Prefer not to disclose

Dentist email address: ***NOTE: email will not be published on our website or shared with others.***

***Please note:*** *Federal requirements states for DWP and Hawki participation the provider's individual NPI and the office's TIN and Organizational NPI must be enrolled with Iowa Medicaid (IM). To verify enrollment or start new application, please contact IM directly at 800-338-7909, email imeproviderservices@dhs.state.ia.us or visit their website (https://hhs.iowa.gov)*

## DEA & CSA REGISTRATION

Do you currently have an active DEA in the state(s) in which you practice? ☐ YES ☐ NO

| DEA # | Expiration Date |
|---|---|

If "NO":

☐ I refer my patients to their Primary Care Physician or Urgent Care / Emergency Room

☐ ______________________ will write my prescriptions for me. (Please list Practicing Provider's DEA #: ___________________________ )

Do you currently have an active CSA / CDS in the state(s) in which you practice? ☐ YES ☐ NO

| CSA # | Expiration Date |
|---|---|

If "NO":

☐ I refer my patients to their Primary Care Physician or Urgent Care / Emergency Room

☐ ______________________ will write my prescriptions for me. (Please list Practicing Provider's CSA #: ___________________________ )

## LICENSE & EDUCATION

| Iowa Dental License # | Expiration Date |
|---|---|

List any active, pending, or inactive licenses to practice dentistry in a state other than Iowa:

| Dental School | Graduation Date | Degree ☐ DDS ☐ DMD ☐ MDS ☐ BDS ☐ MSD |
|---|---|---|
| Graduate / Residency Dental Program | Graduation Date | |

Residency / Postgraduate Training

☐ I do not currently have any specialty training.

☐ Endodontist ☐ Oral Surgeon ☐ Orthodontist

☐ Pediatric Dentist ☐ Periodontist ☐ Prosthodontist

☐ Other: ____________________________________________

Board Certified? ☐ YES ☐ NO

Board Certification Issued By: __________________________

****Please provide a copy of certification.****

## OFFICE / PRACTICE SITE INFORMATION

For additional sites, please utilize Page 7.

Please provide the following information for the primary site at which you practice.

☐ Primary ☐ Secondary ☐ Part-Time ☐ Other (please explain): ______________________

| Practice Location Name | Tax ID Number | Organizational NPI |
|---|---|---|
| | | |

Address (include suite #, if applicable)

| City | State | Zip Code | County |
|---|---|---|---|
| | | | |

| Phone Number | Fax |
|---|---|
| | |

Is the payment address the same as the treatment office address? ☐ YES ☐ NO

| Payment Address (P.O. Boxes are acceptable) | City, State, Zip |
|---|---|
| | |

General Office Email *(required)* — *Note: Email will be listed on the Provider Directory*

Office Website ☐ *We do not have a website.*

Emergency service line available 24 hours per day / 7 days a week? ☐ YES ☐ NO

If no, is there a phone message when office is closed directing patients where to seek emergency care? ☐ YES ☐ NO

a) Does this office comply with ADA standards (accessible parking spaces, exterior and interior routes, entrances, waiting rooms, public restrooms, and employee work areas)?
☐ YES ☐ NO

c) Free parking? ☐ YES ☐ NO

d) Public transit access? (e.g. bus)? ☐ YES ☐ NO

b) In addition, does this office offer the following?

a. Automated doors ☐ YES ☐ NO

b. Wide entries / operatories to accommodate motorized wheelchairs ☐ YES ☐ NO

c. One or more exam rooms where a patient can be treated in their wheelchair ☐ YES ☐ NO

d. Diagnostic equipment to accommodate patients with disabilities ☐ YES ☐ NO

List languages spoken other than English:

## PROVIDER INFORMATION

### Office Hours:

a) Open before 8 AM? ☐ YES ☐ NO

b) After 5 PM? ☐ YES ☐ NO

c) Weekends? ☐ YES ☐ NO

a) Telehealth services available? ☐ YES ☐ NO

b) Accepting new Premier and/or PPO patients? ☐ YES ☐ NO

c) Accepting new DWP adult patients? ☐ YES ☐ NO

d) Accepting new DWP Kids patients? ☐ YES ☐ NO

e) Have you completed cultural competency training? ☐ YES ☐ NO

### Do you treat disabled children?

a) Physical Disability? ☐ YES ☐ NO

b) Intellectual Disability? ☐ YES ☐ NO

### Do you treat disabled adults?

a) Physical Disability? ☐ YES ☐ NO

b) Intellectual Disability? ☐ YES ☐ NO

## WORK HISTORY

☐ Check here if you are a new graduate.

Please list your dentist work history for the last 5 years below. Alternatively, you may attach a current Curriculum Vitae. Provide an explanation for any gaps in work history.

| From *(MM/YYYY)* | Position | | |
|---|---|---|---|
| To *(MM/YYYY)* Current | Employer Name | | |
| Address | | | |
| City | State | ZIP | Phone Number |

| From *(MM/YYYY)* | Position | | |
|---|---|---|---|
| To *(MM/YYYY)* | Employer Name | | |
| Address | | | |
| City | State | ZIP | Phone Number |

| From *(MM/YYYY)* | Position | | |
|---|---|---|---|
| To *(MM/YYYY)* | Employer Name | | |
| Address | | | |
| City | State | ZIP | Phone Number |

Work Gap Explanation:

## HOSPITAL AFFILIATION (IF APPLICABLE)

☐ I do not currently have any hospital or facility privileges.

| From *(MM/YYYY)* | Facility Name | | |
|---|---|---|---|
| To *(MM/YYYY)* | Address | | |
| City | State | ZIP | Phone Number |
| Admitting Privileges: ☐ YES ☐ NO | | | |

| From *(MM/YYYY)* | Facility Name | | |
|---|---|---|---|
| To *(MM/YYYY)* | Address | | |
| City | State | ZIP | Phone Number |
| Admitting Privileges: ☐ YES ☐ NO | | | |

## QUALITY FOCUSED QUESTIONS

An explanation is required if you answer "yes" to any of the following questions. For required explanations, use the section below the questions and include the question number, dates, circumstances, and dispositions.

| Question | | |
|---|---|---|
| 1. Are you **ineligible** for DEA or CSA registrations or has your DEA or CSA certification been denied, revoked, limited, suspended, put on probation, or voluntarily relinquished? *If yes, explanation required.* | ☐ YES | ☐ NO |
| 2. Have you ever been disciplined by a state dental board? *If yes, explanation required.* | ☐ YES | ☐ NO |
| 3. Have you ever been subject to any litigation or had any malpractice claims or suits pertaining to your dental practice filed against you? *If yes, explanation required.* | ☐ YES | ☐ NO |
| 4. Has information pertaining to you been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? *If yes, explanation required.* | ☐ YES | ☐ NO |
| 5. Has your professional license or privileges in any state ever been denied, revoked, limited, suspended, put on probation, or voluntarily relinquished? *If yes, explanation required.* | ☐ YES | ☐ NO |
| 6. Have you ever been convicted of a felony or are any felony charges now pending against you for any reason? *If yes, explanation required.* | ☐ YES | ☐ NO |
| 7. Have you ever been excluded by the federal Office of the Inspector General or denied, expelled, or suspended from participating in a state or federal health care program including Medicare or Medicaid? *If yes, explanation required.* | ☐ YES | ☐ NO |
| 8. Do you presently use any drugs illegally? *If yes, explanation required.* | ☐ YES | ☐ NO |
| 9 Do you presently have a chemical dependency, substance abuse condition, mental health condition, or physical condition (such as infectious disease) that would interfere with your ability to perform the essential functions of the practice of dentistry with or without accommodations? *If yes, explanation required.* | ☐ YES | ☐ NO |

**Explanation of Yes Answer(s) |** Please attach additional explanation on seperate sheet, if needed.

| ) | |
|---|---|
| ) | |
| ) | |
| ) | |

☐ I acknowledge I have reviewed the Fraud, Waste and Abuse Training located on the Dentist Connection under Resources > Education Materials.

☐ I acknowledge DDIA provides American Sign Language and Translation Services at no cost to myself or my patients and that more information is located on the Dentist Connection under Resources > Value-Added Services.

*I understand that it is my responsibility to provide correct and complete credentialing information to DDIA. I certify that the information provided by me is true to the best of my knowledge. I agree to notify DDIA of any changes in this information (including professional liability information) within 30 calendar days. I understand that the information I have provided will be reviewed by DDIA and that other information may be obtained in accordance with the DDIA credentialing program. I further understand that my willingness to provide complete and truthful information will help ensure the continuation of my participating status with Delta Dental.*

Dentist's Signature: ______________________ Date: ______________

## OFFICE / PRACTICE SITE INFORMATION

For additional sites, please copy Page 7.

Please provide the following information for each additional site at which you practice.

☐ Primary ☐ Secondary ☐ Part-Time ☐ Other (please explain): ______________________

| Practice Location Name | Tax ID Number | Organizational NPI |
|---|---|---|
| | | |

| Address (include suite #, if applicable) |
|---|
| |

| City | State | Zip Code | County |
|---|---|---|---|
| | | | |

| Phone Number | Fax |
|---|---|
| | |

Is the payment address the same as the treatment office address? ☐ YES ☐ NO

| Payment Address (P.O. Boxes are acceptable) | City, State, Zip |
|---|---|
| | |

| General Office Email *(required)* *Note: Email will be listed on the Provider Directory* | Office Website ☐ *We do not have a website.* |
|---|---|
| | |

Emergency service line available 24 hours per day / 7 days a week? ☐ YES ☐ NO

If no, is there a phone message when office is closed directing patients where to seek emergency care? ☐ YES ☐ NO

a) Does this office comply with ADA standards (accessible parking spaces, exterior and interior routes, entrances, waiting rooms, public restrooms, and employee work areas)?

☐ YES ☐ NO

c) Free parking? ☐ YES ☐ NO

d) Public transit access? (e.g. bus)? ☐ YES ☐ NO

b) In addition, does this office offer the following?

a. Automated doors ☐ YES ☐ NO

b. Wide entries / operatories to accommodate motorized wheelchairs ☐ YES ☐ NO

c. One or more exam rooms where a patient can be treated in their wheelchair ☐ YES ☐ NO

d. Diagnostic equipment to accommodate patients with disabilities ☐ YES ☐ NO

List languages spoken other than English:

## PROVIDER INFORMATION

### Office Hours:

a) Open before 8 AM? ☐ YES ☐ NO

b) After 5 PM? ☐ YES ☐ NO

c) Weekends? ☐ YES ☐ NO

a) Telehealth services available? ☐ YES ☐ NO

b) Accepting new Premier and/or PPO patients? ☐ YES ☐ NO

c) Accepting new DWP adult patients? ☐ YES ☐ NO

d) Accepting new DWP Kids patients? ☐ YES ☐ NO

e) Have you completed cultural competency training? ☐ YES ☐ NO

### Do you treat disabled children?

a) Physical Disability? ☐ YES ☐ NO

b) Intellectual Disability? ☐ YES ☐ NO

### Do you treat disabled adults?

a) Physical Disability? ☐ YES ☐ NO

b) Intellectual Disability? ☐ YES ☐ NO

DELTA DENTAL

# DELTA DENTAL PARTICIPATING Hawki ORTHODONTIC SERVICES AGREEMENT

This Delta Dental Participating Hawki Orthodontic Services Agreement ("Agreement") is made by and between Delta Dental of Iowa ("Delta Dental") and the undersigned dentist ("Participating Dentist").

RECITALS:

A. Delta Dental has entered into an agreement with the State of Iowa acting by and through the Iowa Department of Human Services, entitled "Contract for Dental Care Services Under the Healthy and Well Kids in Iowa (Hawki) Program" which, among other things, provides for a limited number of orthodontic benefits if Medically Necessary (as hereinafter defined) criteria is met and are listed in specific Hawki Procedure Codes (as hereinafter defined).

B. Participating Dentist wishes to enter into this Agreement to provide such orthodontic benefits under the Hawki Orthodontic Program (as hereinafter defined).

Participating Dentist represents and agrees as follows:

1. All terms capitalized in this Agreement are defined in this Agreement or in the documents incorporated by reference.

   "Covered Enrollee" means any dental patient eligible for orthodontic benefits under the Hawki Orthodontic Program.

   "Covered Services" means orthodontic services listed in Exhibit A to which a Covered Enrollee is eligible under the Hawki Orthodontic Program

   "Hawki Contract" means the "Contract for Dental Care Services Under the Healthy and Well Kids in Iowa (Hawki) Program" dated January 1, 2005 between the State of Iowa acting by and through the Iowa Department of Human Services and Delta Dental of Iowa, as heretofore and hereafter amended.

   "Hawki Orthodontic Fee Schedule" means the fee schedule for specific limited Hawki Procedure Codes listed in Exhibit A to this Agreement.

   "Hawki Orthodontic Program" means the program which provides to Covered Enrollees a limited number of orthodontic benefits that meet Medical Necessity criteria and are listed in specific Hawki Procedure Codes.

   "Hawki Procedure Codes" means the procedure codes listed in Exhibit A to this Agreement.

   "Medical Necessity" or "Medically Necessary" means a Salzmann Index score of 26 or greater.

2. This Agreement, together with any documents incorporated by reference and made a part hereof, constitutes the entire agreement between me and Delta Dental concerning the Hawki Orthodontic Program.

3. Orthodontic procedures will only be approved for handicapping malocclusions, as defined in the Delta Dental Hawki Orthodontic Program Uniform Regulations.

4. Exhibit A sets forth the Covered Services that require prior authorization from Delta Dental. In the event I do not obtain prior authorization for the Covered Services which require prior authorization, Delta Dental shall have no obligation to make payment to me for such Covered Services, and I will not collect, or attempt to collect, my fees from the Covered Enrollee.

5. I will accept from Delta Dental as payment in full for Covered Services rendered to Covered Enrollees the lesser of: (i) the Hawki Orthodontic Fee Schedule attached to this Agreement as Exhibit A, or (ii) my fees for such Covered Services. I shall not bill the Covered Enrollee for the balance, if any, between my fees for such Covered Services and the Hawki Orthodontic Fee Schedule. Delta Dental may revise the Hawki Orthodontic Fee Schedule from time to time by written notice to me. No such revision shall apply retroactively to dental services provided prior to notice of the revision.

6. Delta Dental shall include my name and address in the Delta Dental directory of Hawki Orthodontic Program Participating Dentists distributed to persons eligible under the Hawki Orthodontic Program.

7. I will abide by all of Delta Dental's rules and regulations concerning the Hawki Orthodontic Program, as well as the Delta Dental Hawki Orthodontic Program Uniform Regulations, all of which are incorporated herein by this reference and made a part hereof. Such rules, regulations, and the Delta Dental Hawki Orthodontic Program Uniform Regulations may be amended from time to time by Delta Dental, and such amendments are also incorporated herein by this reference and made a part hereof.

8. I will abide by all Delta Dental credentialing requirements. I will notify Delta Dental in writing of any non-compliance on my part with the requirements of credentialing pursuant to Section 13 of the Delta Dental Hawki Orthodontic Program Uniform Regulations.

9. I will abide by all applicable laws and regulations. I hold a current license to practice dentistry under Chapter 153, Code of Iowa, and have an office located in the State of Iowa. I have not been excluded from participating in Medicare or Medicaid programs.

10. I will cooperate with utilization, pre-treatment and post-treatment review programs established and implemented by Delta Dental.

11. I acknowledge that I am an independent contractor. None of the provisions of this Agreement are intended to create or to be construed as creating any employee-employer, partnership, joint venture, or agency relationship.

12. Delta Dental is not responsible for any wrongful act on my part. I understand I may not subcontract my rights, duties or obligations under this Agreement, in whole or in part, without the prior written consent of Delta Dental.

13. Delta Dental may amend this Agreement from time to time by providing to me at least sixty (60) days advance written notice of the amendment, which notice shall be effective when placed in the U.S. mail, postage prepaid, addressed to me at my address set forth below. The amendment shall become effective (unless I terminate this Agreement as provided in the following sentence) upon the later of: (i) the end of

such notice period, or (ii) the effective date specified in such notice. If I do not accept Delta Dental's proposed amendment, I may terminate this Agreement by certified mail, return receipt requested, sent to Delta Dental at any time during the thirty (30) day period after the date of Delta Dental's notice of amendment, which termination will be effective as of the date the amendment was to have been effective. Notwithstanding the foregoing, if any amendment is required by law, Delta Dental may elect that such amendment shall become effective immediately upon written notice thereof being placed in the U.S. mail, postage prepaid, addressed to me at my address set forth below.

14. I may terminate this Agreement by giving at least sixty (60) days written notice of termination by certified mail, return receipt requested, sent to Delta Dental. Delta Dental may terminate this Agreement as provided in the Delta Dental Hawki Orthodontic Program Uniform Regulations. This Agreement shall terminate concurrently with any termination of the Hawki Contract or the Hawki Orthodontic Program.

15. This Agreement shall become effective upon written notice to me by Delta Dental of Delta Dental's acceptance.

16. This Agreement applies only to the Hawki Orthodontic Program. This Agreement does not apply to any Delta Dental Premier® Participating Dentist's Agreement or any Delta Dental PPO℠ Agreement Supplement to any Delta Dental Premier® Participating Dentist's Agreement which may now or hereafter be in effect between me and Delta Dental, and any such agreements are unaffected by this Agreement.

**Delta Dental and Participating Dentist each hereby irrevocably and unconditionally waives all right to trial by jury in any action, proceeding or counterclaim arising out of or relating to this Agreement.**

| Accepted by: | Participating Dentist: |
|---|---|
| Delta Dental of Iowa on this _______ day of<br>__________________________, ___________.<br><br>_______________________________________<br>Dental Director, Delta Dental of Iowa<br><br>_______________________________________<br>President and CEO, Delta Dental of Iowa | Signature _____________________________________<br>(name of Participating Dentist)<br><br>Print Name ____________________________________<br>Address ______________________________________<br>City/Zip ______________________________________<br>Date __________________________ |

Form HI-001
Effective: 3/1/2010

# Delta Dental of Iowa
# Direct Deposit / Electronic Funds Transfer (EFT)
# Authorization Agreement – Instructions and Enrollment Form

| | |
|---|---|
| **Special Notes** | If you are also participating in Electronic Remittance Advice (ERA)/835, please contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. |
| **Where to Submit Completed Enrollment Form** | Professional Relations<br>Delta Dental of Iowa<br>9000 Northpark Drive<br>Johnston, IA 50131<br>Fax 515-261-5608<br>provrelations@deltadentalia.com |
| **General Instructions** | If you have multiple offices and would like Direct Deposit for each location, you must complete a form for each office location. Accuracy of all information is essential. If you have any questions, please contact Delta Dental's Professional Relations Team. |
| **Delta Dental of Iowa Contact Information** | Professional Relations<br>Delta Dental of Iowa<br>9000 Northpark Drive<br>Johnston, IA 50131<br>800-544-0718<br>Fax 515-261-5608<br>provrelations@deltadentalia.com |
| **Enrollment Confirmation** | Once enrollment processes are complete, Delta Dental of Iowa will notify the provider via email or phone call to confirm the Direct Deposit/EFT start date. |
| **Late or Missing Direct Deposit/EFT** | If the expected Direct Deposit/EFT appears to be late or missing, please contact Delta Dental of Iowa's Professional Relations Team at 800-544-0718 or provrelations@deltadentalia.com. |

DELTA DENTAL

www.deltadentalia.com

# Delta Dental of Iowa Direct Deposit / Electronic Funds Transfer (EFT) Enrollment Form

## PROVIDER INFORMATION

**Provider Name**

______________________________

**Provider Address**

(Street) ______________________ (City) ______________________ (State) ________ (ZIP Code) ________

## PROVIDER IDENTIFIERS INFORMATION

**Provider Identifiers**

______________________________
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

______________________________
National Provider Identifier (Individual Provider - NPI 1)

______________________________
National Provider Identifier (Organizational - NPI 2)

## PROVIDER CONTACT INFORMATION

**Provider Contact Name:**

______________________________

______________________________
Telephone Number

______________________________
Email Address

## FINANCIAL INSTITUTION INFORMATION

**Financial Institution Name:** ______________________________

**Financial Institution Telephone Number:** ______________________________

**Financial Institution Routing Number:** ______________________________

**Type of Account at Financial Institution:** ❑ **Checking** ❑ **Savings**

**Provider's Account Number with Financial Institution:** ______________________________

**Account Number Linkage to Provider Identifier:** ______________________________
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

DELTA DENTAL

www.deltadentalia.com

## SUBMISSION INFORMATION

**Reason for Submission**

(check one) ❑ New Enrollment ❑ Change Enrollment ❑ Cancel Enrollment

**Include with Enrollment Submission**

(check one) ❑ Voided Check
❑ Bank Letter (A letter on bank letterhead that formally certifies the account owners routing and account numbers)

**Authorized Signature** (The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment) This authority is to remain in full force and effective until Delta Dental of Iowa (DDIA) receives written notification from me/us of its termination in such time and manner as to afford DDIA reasonable opportunity to act on it. In addition, I (we) certify to the best of my (our) knowledge that the banking information given is not that of a foreign banking institution (located outside of the United States).*

**Please sign, date and return completed form, along with voided check or bank letter to: Professional Relations, Delta Dental of Iowa, 9000 Northpark Dr., Johnston, IA 50131 or Fax to 515-261-5608**

______________________________________________
Written Signature of Person Submitting Enrollment and Title

______________________________________________
Printed Name of Person Submitting Enrollment

**Submission Date:** ______________________

**Requested Direct Deposit Start/Change/Cancel Date:** ______________________

*If you banking institution is a foreign bank, please contact Delta Dental of Iowa at 800-544-0718 for further instructions.

## REMITTANCE ADVICE DELIVERY

**Delivery Option:**

❑ E-mail notification with delivery of the Remittance Advice to the website

______________________________________________
E-mail to receive direct deposit notification

**Delta Dental of Iowa Administrative Use Only:**

| Date | DDIA Representative Initials | Payee Number |
|---|---|---|
| | | |

# DELTA DENTAL NATIONAL EFT/ERA AUTHORIZATION FORM

Delta Dental of Iowa is making enhancements to allow you to receive Electronic Funds Transfers (EFT) from all Delta Dental Member companies, and not just Delta Dental of Iowa. This solution will simplify electronic payments to participating providers and provide access to Electronic Remittance Advice (ERA) information. This means that all dentists signed up for direct deposit (EFT) can be enrolled in to accepting direct deposit from other Delta Dental member companies instead of receiving a paper check if you opt in to the National EFT/ERA feature by signing below. If you currently receive direct deposit from Delta Dental of Iowa and do not wish to opt into the national solution you do not need to do anything. Your office will continue to receive direct deposit (EFT) from Delta Dental of Iowa.

☐ Yes, I wish to receive Delta Dental National EFT/ERA

Email: ______________________________________________

By marking the above and returning this form with signature, I give consent to Delta Dental of Iowa to provide my direct deposit information to other Delta Dental member companies. I do understand I will continue to receive direct deposit(s)/electronic funds transfers (EFT) from Delta Dental of Iowa with access to Remittance Advice (RA) / Electronic Remittance Advice (ERA).
In consideration for the provision of direct deposit services, by signing below, and notwithstanding 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 Delta Dental of Iowa under the heading "Banking Information", 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 45 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 conjunction 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 information provided under the heading "Banking 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.

Dentist / Office Name: ______________________________________________

Address, City, State, Zip: ______________________________________________

Office Phone Number: ______________________________

Provider Tax ID#: ______________________________ NPI: ______________________

Authorized Signature: ______________________________ Title: ______________________

**Please mail or fax form back to:**

Attn: Professional Relations
Delta Dental of Iowa
9000 Northpark Drive
Johnston, Iowa 50131

Fax: 515-261-5608

**Questions?**

Contact Delta Dental of Iowa Professional Relations at provrelations@deltadentalia.com or 800-544-0718

Form **W-9** (Rev. October 2018) Department of the Treasury Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

**Give Form to the requester. Do not send to the IRS.**

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ ________

**Note:** Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

*(Applies to accounts maintained outside the U.S.)*

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* 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. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**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 for Part II, later.

**Sign Here** **Signature of U.S. person ▶** **Date ▶**

# General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments**. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See* What is backup withholding, *later.*

# OWNERSHIP & CONTROL DISCLOSURE FORM

Delta Dental of Iowa is obligated by law to ensure it is not doing business with a person or entity that has been excluded from participation in government programs.[1] Completion and submission of this form is a condition to participation in any government program. Please complete this form as fully as possible. You must disclose all responsive information you know or should know. You ensure all information is accurate and must immediately report any changes by completing a new form. Thank you.

| Entity Name: | Tax I.D. Number: |
|---|---|
| Individual NPI (if applicable): | Organizational NPI (if applicable): |

A. Required Disclosures. Below, providers need to disclose 1) each person or entity that has a direct or indirect[2] ownership or control interest in the above entity, 2) each person who is a managing employee[3] of the above entity, 3) any subcontractor[4] in which the above entity has a direct or indirect ownership of five percent (5%) or more, 4) the family relationship, if any, between those with ownership or control interests in the above entity, 5) any other business entities involved with a government program in which the persons listed below have an ownership or control interest, 6) the ownership of any subcontractor to which the above entity has paid more than $25,000 during the last year, 7) any wholly-owned supplier with which the above entity has any significant transactions during the last 5 years, and 8) any subcontractor with which the above entity has had any significant transactions the last 5 years. **Please use tables on pages 3-4 to disclose the information in response to each category.**

B. Final Adverse Actions. Delta Dental of Iowa is obligated to determine whether any provider, supplier or any owner of any provider or supplier has been the subject of a final adverse action. Such disclosure is required for all persons or entities listed herein and the disclosing entity. All final adverse actions must be reported, regardless of whether the action has been appealed or expunged. You are required to report all final adverse actions within 30 days of the event. A final adverse action means any convictions of criminal offenses related to or arising from any Medicare, Medicaid, or Title XX program, including any felony or misdemeanor convictions. It also includes any revocation, suspension or surrender of any health care-related license or accreditation and any suspension, revocation, exclusion or disbarment from participation in or any other sanction imposed by a federal or state health care program or any federal executive branch procurement or non-procurement program.

On page 4, please list all persons and entities disclosed above and 1) if the person or entity has not had a final adverse action, put an "N" in the "Y or N" box after the name; 2) if the person or entity has had a final adverse action, put a "Y" in the "Y or N" box and provide the requested details.

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[1] 42 C.F.R. § 438.610; 42 C.F.R.§§ 455-104-106; 42 C.F.R. §§ 424.516, 519

[2] Direct ownership includes possession of equity in the capital, stock or profits of entity identified above. Indirect ownership includes an ownership interest in an entity that owns the entity identified above or an ownership interest in any entity that has an indirect ownership interest in the entity identified above.

[3] A managing employee means a general manager, business manager, office manager, administrator, director, or any person who exercises operational or managerial control over the disclosing entity. This includes any independent contractor in such a position.
All managing employees at all the disclosing entity's locations must be disclosed.

[4] Subcontractor means a person or entity to which the disclosing entity as contracted or delegated some management function(s) or responsibility of providing medical care, and any person or entity with which the fiscal agent has entered into an agreement to obtain space, goods or services provided under the Medicaid agreement.

C. Other Affiliations. Does the disclosing entity have any current or previous direct or indirect affiliation[5] with a present or former Medicaid provider? ☐ Y ☐ N. If yes, please identify the Medicaid provider(s) on page 4.

D. Outstanding Debt. Do any of the persons or entities listed part B. above have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa state governments? ☐ Y ☐ N ☐ Unknown. If yes, please identify the person or entity on page 4.

E. Other Sanctions. Have any of the persons or entities listed in part B. above been subject to a payment suspension under a federally-funded health care program, had billing privileges denied or revoked, or been excluded from participation under any federally-funded health care program?

- Payment Suspension: ☐ Y ☐ N ☐ Uknown
- Denied or Revoked Billing Privileges: ☐ Y ☐ N ☐ Uknown
- Excluded: ☐ Y ☐ N ☐ Uknown. If yes to any, please identify the person or entity on page 4.

F. National Provider Identifier (NPI). Do any of the persons or entities listed in part B. share a NPI or Federal Tax Identification number with another provider who has uncollected debt?
☐ Y ☐ N ☐ Unknown. If Yes, please identify the person or entity on page 4.

**The disclosing entity certifies that the information submitted on this form is true, accurate and complete to the best of the entity's knowledge; that the disclosing entity has read all entries before signing; the disclosing entity agrees to contact Delta Dental of Iowa within 30 days of any changes in the information herein; the disclosing entity understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal or state law. Thank you very much.**

| Printed Name of Legal Entity Signatory: | |
|---|---|
| Signature: | Date: |

**Please use following pages for disclosures.**

[5] Affiliation includes, but is not limited to, direct or indirect relationships between individuals or entities or a combination of the two. Such a relationship includes, but is not limited to, a compensation arrangement, an ownership arrangement, managerial authority over any member of the affiliation, the ability of one member of the affiliation to control the other, or the ability of a third party to control a member of the affiliation.

**Please use these tables to complete your disclosures. They reference the parts of this disclosure form above. If you need more space, please copy this form for use.**

## A.1) OWNERS

| Name (Legal and Doing Business) | Address | Social Security or Taxpayer ID Number | Describe Ownership Interest |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |

## A.2) MANAGING EMPLOYEES

| Name | Date of Birth | Social Security Number | Job Title |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |

## A.3) SUBCONTRACTOR OWNERSHIP (5% OR MORE)

| Name | Tax ID Number | Address |
| --- | --- | --- |
| | | |
| | | |
| | | |

## A.4) FAMILY RELATIONSHIPS

| |
| --- |
| |
| |
| |
| |

## A.5) OTHER OWNED ENTITIES

| Name | Fiscal Agent / Medicaid No. | Tax ID Number | Primary Address |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |

## A.6) SUBCONTRACTORS PAID $25,000

| Name | Tax ID Number | Address |
| --- | --- | --- |
| | | |
| | | |
| | | |

## A.7) OWNED SUPPLIER SIGNIFICANT TRANSACTIONS

| Name | Tax ID Number | Address |
|---|---|---|
| | | |
| | | |
| | | |

## A.8) SUBCONTRACTOR SIGNIFICANT TRANSACTIONS

| Name | Tax ID Number | Address |
|---|---|---|
| | | |
| | | |
| | | |

## B) FINAL ADVERSE ACTIONS

| Name | Y or N | Date | Action Taken | Resolution |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## C) OTHER AFFILIATIONS

| Name of Person or Entity | Primary Address | Tax ID Number | Primary Address |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## D) OUTSTANDING DEBT

| Name of Person or Entity | Primary Address |
|---|---|
| | |
| | |
| | |

## E) OTHER SANCTIONS

| Name of Person or Entity | Primary Address | Type of Sanction |
|---|---|---|
| | | |
| | | |
| | | |

## F) NATIONAL PROVIDER IDENTIFIER

| Name of Person or Entity | Primary Address | NP or Tax ID Number |
|---|---|---|
| | | |
| | | |
| | | |