

## AGREEMENT

THIS AGREEMENT is made this     day of     , 2011, by and between SELE-DENT, INC., 381 Sunrise Highway, Suite 307 Lynbrook, New York 11653 and

DENTIST: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

WHEREAS, SELE-DENT, INC., has established a network of Dentists to render services to employees/members (“Eligible Participants”) of certain employers, unions and organizations (“Clients”);

WHEREAS, the Dentist wishes to become a member of such Network; and

WHEREAS, this Agreement shall set forth the terms and provision of the understanding of the parties.

NOW, THEREFORE, in consideration of the mutual covenants and provisions contained herein, the parties agree as follows:

### SECTION ONE – Dentist Obligations

- 1.1 Dentist agrees to become a member of Sele-Dent’s Network of Dentists. Dentist shall maintain at all times a valid, full and unrestricted license to practice dentistry. Dentist agrees to abide by Preferred Provider’s (as such term is defined in Section 1.3, below) credentialing requirements. Dentist shall participate in continuing education not less than in accordance with generally accepted dental practice standards at the time and in accordance with applicable credentialing standards. Dentist shall maintain dental records in accordance with applicable state and federal laws, regulations, and requirements.
- 1.2 Dentist shall be solely responsible for the quality and appropriateness of services rendered to Eligible Participants. Dentist shall be responsible for verifying that an individual is an Eligible Participant who is covered for dental services and the number of visits to which the Eligible Participant is entitled. Verification may be attained through identification card, facsimile or telephone authorization.
- 1.3 Dentist agrees to accept any individual who is enrolled in a Health Plan and entitled to receive benefits for certain health care services under a Subscription Agreement with any organization or entity (a “Preferred Provider”) which has contracted with Sele-Dent, Inc.

A Health Plan” shall mean any plan, group insurance policy, prepaid or fee for service agreement, contract, program or other similar arrangement entered into with a Payor (as defined below), including such plans or arrangements created or established under the auspices of a managed care “no-fault” automobile insurance program or a managed care workers’ compensation program, which provides for the payment, reimbursement and/or furnishing of health services to Eligible Participants. A “Payor” shall mean those entities which have contracted with Sele-Dent, Inc. or with any Preferred Provider to provide reimbursement to Dentist as part of such Preferred Provider’s fee schedule for covered services.

- 1.4 Dentist shall have the ultimate responsibility for services provided to Eligible Participants, including but not limited to, all dentist-patient responsibilities, referrals to specialists and/or health care providers. Dentist shall be solely responsible for all decisions regarding health care of Eligible Participants receiving care in his/her practice.
- 1.5 Dentist will render covered services to Eligible Participants in the same manner and with the same degree of quality, as he/she does for his/her private patients in a non-discriminatory manner.
- 1.6 Dentist hereby agrees that Dentist will not deny the provision of Covered Services to Eligible Participants by virtue of the Eligible Participant being covered by any agreement between Sele-Dent, Inc. and a Preferred Provider.
- 1.7 If a referral is necessary, either to a physician, dentist, clinical laboratory or diagnostic center, Dentist agrees to refer eligible participants to a Preferred Provider participant from a list provided by Sele-Dent, Inc. Prior approval from Preferred Provider is required for referral to non-participating physicians or other non-participating health care providers except in situations where there will be an immediate and substantial bodily injury to an Eligible Participant in the absence of intervention of a non-participating health care provider. Under such circumstances, Dentist agrees to notify the Preferred Provider and Sele-Dent, Inc. within 24 hours.
- 1.8 Dentist agrees to cooperate with Sele-Dent, Inc. and all Preferred Providers and their payors or payor’s designees, concerning utilization review procedures, quality assurance programs, credentialing and recredentialing programs, policy guidelines and referral procedures.
- 1.9 Dentist agrees not to seek or accept additional compensation or reimbursement from any Eligible Participant for Covered Services except for:
  - (a) co-payment;
  - (b) deductibles;
  - (c) amounts due for non-covered services; and
  - (d) co-insurance.

Dentist agrees to assure that payment is obtained from Worker's Compensation or no-fault auto insurance when such payments are available. Dentist further agrees to accept a Preferred Provider's maximum allowable fee schedule for State Workers' Compensation schedule for Dentist's applicable region, whichever is less, for those Eligible Participants who are enrolled in a Preferred Provider's managed care worker's compensation program or a managed "no-fault" program. Such Eligible Participants will be identifiable by a special designation on an Eligible Participant's ID card. Only if a Dentist is approved by the Preferred Provider will Dentist receive reimbursement for the performance of specialized procedures. Except as set forth above, if due to a payor's utilization review activity or a Preferred Provider's utilization review activity, there is a reduction or denial of benefits, Dentist agrees not to bill or otherwise attempt to collect those amounts from the Eligible Participant.

- 1.10 Dentist agrees to maintain specialty appropriate professional liability insurance policies of a minimum of \$1 million per claim/\$3 million for all claims in greater amounts if deemed necessary by Sele-Dent, Inc. Dentist further agrees to provide Sele-Dent, Inc. evidence that such policy is in force.
- 1.11 Dentist agrees to immediate verbal notification, followed by written notification within three (3) business days in the event of the following.
  - (a) Change of Dentist's office address or billing and/or telephone number; or
  - (b) Change of Dentist's tax ID number;
  - (c) Any action taken resulting in final decision to restrict, suspend or revoke license to practice dentistry or his/her dental staff privileges;
  - (d) Any action taken to censure, reprimand or fine Dentist or place Dentist on probation;
  - (e) Any lawsuit filed against the Dentist for malpractice and the final disposition of legal action;
  - (f) A lapse, cancellation or modification of Dentist's professional liability insurance as required by this Agreement; or
  - (g) Any other situation that might affect Dentist's ability to carry out his/her duties or obligations under this Agreement.
- 1.12 Dentist agrees to permit Sele-Dent, Inc., and a Preferred Provider to use his/her name, address, telephone number and description of services in the Directory of Participating Providers and any other materials necessary.
- 1.13 Dentist agrees to cooperate with Sele-Dent, Inc. and any Preferred Provider in resolving any grievances related to Dentist's Covered Services to Eligible Participants or administrative issues.

- 1.14 Should an Eligible Participant's benefit program require the payment of any deductibles, co-payments, or co-insurance amounts, Dentist shall collect and retain the amount payable by the covered person. The fee paid, along with the monies collected shall not exceed the amount shown in the fee schedule. Dentist may charge and collect for non-covered services when the covered person has requested such services and has been advised that such services are non-covered.
- 1.15 All claims for Covered Service rendered to Eligible Participants shall be submitted within fifty-five (55) days of the date of service. Claims submitted after eleven (11) months from the date of service will not be honored.
- 1.16 Dentist agrees to make all arrangements to ensure twenty-four (24) hour/three hundred sixty-five (365) days per year availability or coverage of healthcare services by a Sele-Dent, Inc. Provider to all Eligible Participants under his/her care.
- 1.17 Dentist must provide ninety-five (95) days prior written notice to Sele-Dent, Inc. if he or she elects not to accept additional covered Eligible Participants.

#### SECTION TWO – Sele-Dent, Inc. Obligations

- 2.1 Sele-Dent, Inc., agrees to market Dental services as a Preferred Provider in the Sele-Dent, Inc. Network to all its prospective clients.
- 2.2 Sele-Dent, Inc., will assure that its clients print a Directory of participating dentists which will be made available to their members/employees.
- 2.3 A copy of the Directory will be provided to each Dentist participating in the Network.
- 2.4 Sele-Dent, Inc. agrees to pay Dentist within 30 business days after Sele-Dent, Inc.'s receipt of payment for a Covered Service from a Payor. Sele-Dent, Inc. will make a best effort to enforce such Agreement. However, Sele-Dent, Inc. is not responsible for payment of claims unless it has received reimbursement from a Payor for a Covered Service.
- 2.5 Fees for services covered under this Agreement will be paid by Sele-Dent, Inc. clients to the Dentist. Dentist agrees not to seek or accept payment from any Eligible Participant for Covered Services except as stated in Section 1.9 and 1.14 supra. The fee will be as per the agreed upon fee schedule, a sample of which is attached hereto as Exhibit I. Dentist agrees to accept this payment as payment in full for Covered Services rendered.
- 2.6 Claims for payment must be submitted by the Dentist to Sele-Dent, Inc. or when designated by Sele-Dent, Inc. directly to its clients, or universal insurance claim forms and must be complete, accurate and legible. Claims shall be completed using CPT-4 coding as well as ICD-9 Diagnosis Coding.

### SECTION THREE – Confidentiality

Subject to Federal and State laws, rules and regulations, Dentist agrees to permit Sele-Dent, Inc., and any Preferred Provider, access to Eligible Participants' dental records in connection with its utilization review, quality assurance programs, peer or grievance reviews and also agrees to follow Sele-Dent, Inc. or its representatives to inspect office sites when required. Further, each party agrees that all documents, all records pertaining to a patient's personal, dental and treatment history, and all communications relating to this Agreement shall be deemed confidential and that it will not disclose such documents, records, information and communications to anyone else. Notwithstanding the foregoing, at Eligible Participant's request or with Eligible Participant's permission, records may be transferred to consultants and related professionals involved in the Eligible Participants' care.

### SECTION FOUR – Effective and Termination Dates

- 4.1 This Agreement shall become effective when signed by both parties. The initial term of this Agreement shall be for one year from the effective date. This Agreement will be automatically renewed at each anniversary date for an additional one (1) year term.
- 4.2 Should either party desire to terminate this Agreement at any time, without cause, written notice must be provided at least ninety (90) days prior to the effective date of such termination.
- 4.3 This Agreement may be terminated upon receipt by Sele-Dent, Inc. of written notification from any Preferred Provider or Payor stating that it has received evidence that the Dentist has falsified or failed to report any credentialing or malpractice information or Dentist's license to practice dentistry or dispense narcotics is revoked, restricted, suspended, voluntarily relinquished or made subject to probationary terms; limitation, reduction or loss of hospital privileges for a period longer than fifteen (15) days; lapse, loss or reduction of professional liability insurance below the \$1 million/\$3 million limits pursuant to this Agreement.
- 4.4 Each party may terminate this Agreement upon written notice in the event of a default in the performance of any of the other party's obligations under this Agreement which default is not satisfactorily cured within thirty (30) days of receipt of written notice of said default.
- 4.5 Either party may terminate this Agreement immediately upon written notice in the event the other party ceases doing business as a going concern, dissolves, has a receiver appointer, makes an assignment for the benefit of creditors or commences a proceeding under any bankruptcy or insolvency laws.

- 4.6 Following the effective date of termination, this Agreement shall be of no further force of effect, except that each party is liable for any obligations or liabilities arising from activities carried on by it hereunder to the effective date of termination of this Agreement.
- 4.7 In the event of termination of this Agreement, Dentist shall immediately notify any Eligible Participant seeking the professional services of Dentist after the date of such termination that Dentist is no longer a Dentist participating in the Sele-Dent, Inc. Network, and he/she will refer the Eligible Participant directly to Sele-Dent, Inc. for further disposition.
- 4.8 Notwithstanding other termination provisions of this Agreement, this Agreement may be unilaterally amended by Sele-Dent, Inc. upon thirty days written notice. If the Dentist determines that he/she wishes to leave the Network rather than accept the amendment to the Agreement, the Dentist is obligated to notify Sele-Dent, Inc. within the 30 day period and to cease seeing new patients at the close of the 30 day period. If Dentist is in the middle of treating a patient, Dentist may continue to see such patient at the current Sele-Dent, Inc. fee schedule until patient finds another Dentist or 60 days have elapsed, whichever is shorter.

#### SECTION FIVE – Miscellaneous

- 5.1 This Agreement is governed by the laws of the State in which the treatment is rendered. For those providers practicing in New York and New Jersey, the State in which treatment was rendered is the jurisdiction which is applicable.
- 5.2 Sele-Dent, Inc. and Dentist are independent legal entities and are performing the services hereunder as independent contractors and no joint venture, partnership, employment, agency or other relationship is created by this Agreement. Neither Dentist or Sele-Dent, Inc. is authorized to represent the other for any purposes.
- 5.3 This Agreement may not be assigned by Dentist to any other person or practitioner without the express written approval of Sele-Dent, Inc.
- 5.4 Any notice required hereunder should be given in writing and sent by first class mail to the other party at the address set forth herein or such other address as may be designated. Such notice shall be effective upon receipt.
- 5.5 This Agreement, together with all Exhibits incorporated herein constitutes the entire Agreement between the parties hereto.

Please sign and date this Agreement on page 7.

IN WITNESS WHEREOF this Agreement has been executed by the parties hereto on the dates set forth below.

Date: \_\_\_\_\_

Dentist  
Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_

SELE-DENT, INC.

Date: \_\_\_\_\_

By: \_\_\_\_\_

381 Sunrise Highway, Suite 307  
Lynbrook, NY 11563  
516-887-7566

**PRACTICE INFORMATION AND LETTER AGREEMENT FORM**

COMPLETE, SIGN AND RETURN TO: SELE-DENT, INC.  
381 SUNRISE HIGHWAY, SUITE 307  
LYNBROOK, NY 11563

**PERSONAL DATA**

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|           |            |                |                                       |
|-----------|------------|----------------|---------------------------------------|
| Last Name | First Name | License Number | Tax I.D. Number for Insurance Billing |
|-----------|------------|----------------|---------------------------------------|

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|         |           |      |               |
|---------|-----------|------|---------------|
| Address | Suite No. | City | Date of Birth |
|---------|-----------|------|---------------|

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|       |     |        |
|-------|-----|--------|
| State | Zip | County |
|-------|-----|--------|

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|                      |               |         |
|----------------------|---------------|---------|
| Telephone Office ( ) | Emergency ( ) | Fax ( ) |
|----------------------|---------------|---------|

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|               |        |                |
|---------------|--------|----------------|
| Dental School | Degree | Year Graduated |
|---------------|--------|----------------|

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General Practice     Specialty \_\_\_\_\_  
 Board Eligible     Board Certified    Do you limit your practice to your specialty  Yes     No

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Post Graduate Courses (Dates & Description)

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Professional Organizations

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List other dental panels which you are a member of

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**OFFICE USE ONLY**

**PARTICIPATING PROVIDER APPLICATION**  
 (Please type or print clearly and complete all sections of application.  
 Use N/A for not applicable. Leave no blanks.)

\_\_\_\_\_ (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (M.I.) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ [ ] Male [ ] Female SS# \_\_\_\_\_  
 Mo. Day Year

Are you applying as a [ ] Primary Care Provider [ ] Referral Specialist [ ] Both

Are you accepting new patients? [ ] Yes [ ] No

If yes, do you have any practice limitations? [ ] Yes [ ] No

If yes, specify \_\_\_\_\_  
 \_\_\_\_\_

Do you accept Worker's Comp. Patients? [ ] Yes [ ] No Workers Comp. # \_\_\_\_\_

Medicaid #: \_\_\_\_\_

**I. CREDENTIALS AND WORK HISTORY**

| FULL NAME OF INSTITUTION  | CITY, STATE | DATES<br>From/To | DEGREE |
|---|-------------|------------------|--------|
| Undergraduate School  |             |                  |        |
| _____   | _____       | _____            | _____  |
| Dental School   |             |                  |        |
| _____   | _____       | _____            | _____  |
| Other (including residency, fellowship, training and professional work history) |             |                  |        |
| _____   | _____       | _____            | _____  |

Teaching appointments \_\_\_\_\_  
 \_\_\_\_\_

Professional Society and Civic Association Memberships \_\_\_\_\_  
 \_\_\_\_\_

**Please attach a copy of our curriculum vitae (CV) which includes prior hospital affiliations and employers.**

Board Certified? [ ] Yes [ ] No Year \_\_\_\_\_ Expiration \_\_\_\_\_ Board Eligible? [ ] Yes [ ] No  
 Board Eligible until \_\_\_\_\_

If Board Eligible, expected exam date(s)? \_\_\_\_\_

**Please attach copies of Board Specialty Certificates.**

\_\_\_\_\_  
Primary State of Licensure License No. Expiration Date

\_\_\_\_\_  
Secondary State of License License No. Expiration Date

**Please attach signed copies of your license(s).**

Federal DEA Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

State DEA/CDS Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Please attach copies.**

**II. PROVIDER DIRECTORY INFORMATION**

Specify Tax Identification Number (T.I.N.) used for billing at each address. Indicate which offices are handicapped accessible.

**Principal Office Address**

\_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Telephone)

TIN# \_\_\_\_\_

Handicapped Accessible  Y  N

**Second Office Address**

\_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Telephone)

TIN# \_\_\_\_\_

Handicapped Accessible  Y  N

**Third Office Address**

\_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Telephone)

TIN# \_\_\_\_\_

Handicapped Accessible  Y  N

**Residence**

\_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Telephone)

TIN# \_\_\_\_\_

|                  | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|------------------|--------|---------|-----------|----------|--------|----------|
| Principal Office |        |         |           |          |        |          |
| Secondary Office |        |         |           |          |        |          |

- Do you make house call?  Yes  No
- Do you speak a foreign language?  Yes  No Specify language(s) \_\_\_\_\_
- Does any member of your staff speak a foreign language?

Language(s): \_\_\_\_\_  Yes  No Specify  
 If yes, specify at which office  
 site: \_\_\_\_\_

- Is your office computerized  Yes  No  
 If yes, type of software \_\_\_\_\_
- Does your office bill electronically?  Yes  No

Please list below the names of any hospitals, facilities or health care organizations with which you have active association, employment, privileges, or practice. **If additional space is required, please attach a separate sheet. Please specify type of privileges (attending, consulting, etc.)**

Facility Name \_\_\_\_\_  
 Dept. \_\_\_\_\_

Address \_\_\_\_\_

Date of Association \_\_\_\_\_

Type of Privileges \_\_\_\_\_

Facility Name \_\_\_\_\_  
 Dept. \_\_\_\_\_

Address \_\_\_\_\_

Date of Association \_\_\_\_\_

Type of Privileges \_\_\_\_\_

Do you have any limitations of privileges at any of the above hospitals? • Yes  No

• If yes, attach full details.

Was your association, employment, privileges or practice at any institution, facility, or health care organization ever discontinued, restricted, suspended, voluntarily surrendered in lieu of pending adverse action or been made subject to supervision or probationary terms? • Yes [ ] No [ ]

• If yes, attach full details.

(1)  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
Telephone# \_\_\_\_\_

(2)  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
Telephone# \_\_\_\_\_

(3)  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
Telephone# \_\_\_\_\_

Which of your covering Dentists will participate in Sele-Dent, Inc.? [ ] 1 [ ] 2 [ ] 3

### III. DENTAL LIABILITY

#### LIABILITY INFORMATION

Do you have professional liability coverage? Yes [ ] No [ ]

Name of Carrier \_\_\_\_\_ Policy \_\_\_\_\_

Coverage Limits: \_\_\_\_\_ Per Occurrence \_\_\_\_\_  
Aggregate \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Have you changed your professional liability carrier within the past ten years? • Yes [ ] No [ ]

• If yes, please list your previous carrier(s), period(s) of coverage and policy number(s) on a separate sheet.

Do you have any general liability coverage? [ ] Yes [ ] No

Name of Carrier \_\_\_\_\_ \$ \_\_\_\_\_

Coverage Limits \_\_\_\_\_

#### Questions

• Are you presently involved in any malpractice suit(s)? • Yes [ ] No [ ]

• Have you ever previously been involved in a malpractice suit? • Yes [ ] No [ ]

• Has any payment been made by you, or on your behalf, as a result of a malpractice claim settlement not involving litigation, a settlement that occurred prior to a judgment involving litigation, or a settlement that was the result of a judgment involving litigation? • Yes [ ] No [ ]

• If you answered yes to any of the above questions, please complete the following medical malpractice history form for each case in which you were involved within the past ten years which includes both new and resolved cases. If you answered yes to any of the above questions but have not been involved in any pending or settled claims within the past 10 years, so state.

The above information will be kept in strict confidence.

Please complete this section if you reported any malpractice actions on your application. If additional sheets are required, please photocopy this page prior to completion. A separate sheet should be used for each malpractice action.

Name of Patient \_\_\_\_\_

Your relationship to patient:

Attending Dentist  Attending Oral Surgeon  Assistant Oral Surgeon  Consultant  Other

Location of Incident: \_\_\_\_\_ Date  
Reported: \_\_\_\_\_

Insurance  
Carrier: \_\_\_\_\_

Additional  
Defendants: \_\_\_\_\_

**Status of Claim**

Check appropriate box:

Open  Closed

If closed, indicate method of closing:  Dismissal  Dropped  Settled  Judgment

Amount of Settlement or  
Judgment: \_\_\_\_\_

Date of Payment: \_\_\_\_\_ -

Please describe the care your rendered and treatment prescribed for the patient.

Condition and diagnosis at time of incident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dates and description of treatment  
rendered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Condition of patient subsequent to  
treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The above information will be kept in strict confidence.**

- Has your license to practice dentistry in any state ever been revoked, restricted, suspended, voluntarily surrendered in lieu of pending adverse action, or been made subject to probationary terms, reprimand, censure, supervision or fine?  
• Yes [ ] No [ ]
- Has your license to dispense or prescribe any narcotic ever been denied, revoked, restricted, suspended, voluntarily surrendered in lieu of pending adverse action, or been made subject to probationary terms?  
• Yes [ ] No [ ]
- Have you ever been the subject of an investigation into possible wrongdoing by any administrative agency (Federal, State or Local) including but not limited to Medicare, Medicaid, or CUA program authorities?  
• Yes [ ] No [ ]
- Have you ever been placed on probation, fined, suspended, reprimanded or censured by and Federal, State or Local agency, including but not limited to Medicare, Medicaid or CUA program authorities?  
• Yes [ ] No [ ]
- To your knowledge, has information pertaining to you ever been reported the National Practitioner Databank?  
• Yes [ ] No [ ]
- Have you ever been convicted for violation of law other than a traffic offense or been the subject of a criminal incident?  
• Yes [ ] No [ ]
- Have you been the subject of any Civil suit concerning professional misconduct (other than malpractice, which is addressed previously)?  
• Yes [ ] No [ ]
- Do you have any physical or mental health condition, treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and requested specialty(ies) or which in any pose a risk of harm to your patients?  
• Yes [ ] No [ ]
- Have you ever been the subject of any complaints concerning inappropriate sexual conduct, harassment, or exploitation?  
• Yes [ ] No [ ]
- Has disciplinary action ever been taken against you by an ethics committee, licensing board, professional association or educational, training or healthcare institution organization?  
• Yes [ ] No [ ]
- Have you ever had your membership in any professional, organization or association revoked, suspended, denied, or not renewed by association choice?  
• Yes [ ] No [ ]
- Have you ever voluntarily relinquished membership in any professional, organization or association in lieu of pending adverse action?  
• Yes [ ] No [ ]
- Are you currently under investigation or have you ever been convicted, suspended or assessed a civil penalty under the anti-fraud and abuse provisions of the a Medicare or Medicaid programs.  
• Yes [ ] No [ ]
- Have you ever had or do you have any limitations or admitting, surgical or other privileges in any hospital, institution, or healthcare facility other than those listed on the third page of this application.  
• Yes [ ] No [ ]

- Have you ever voluntarily relinquished membership in any professional, organization or association in lieu of pending adverse action? • Yes [ ] No [ ]
  - Are you currently under investigation or have you ever been convicted, suspended or assessed a civil penalty under the anti-fraud and abuse provisions of the a Medicare or Medical programs. • Yes [ ] No [ ]
  - Have you ever had or do you have any limitations or admitting, surgical or other privileges in any hospital, institution, or healthcare facility other than those listed on the third page of this application? • Yes [ ] No [ ]
  - Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic center, hospital, surgi-center, or other business dealing with the provision of health services, equipment or supplies? • Yes [ ] No [ ]
- **If yes to any of the above, please provide details. Attach additional pages if necessary.**

PROFESSIONAL CORP.                       PARTNERSHIP                       IPA                       OTHER

Type of Practice: Solo \_\_\_\_\_ Single Specialty Group \_\_\_\_\_ Multi Specialty Group \_\_\_\_\_

Name \_\_\_\_\_ of  
Practice \_\_\_\_\_

Practice Specialty(ies): \_\_\_\_\_

Tax Identification Number \_\_\_\_\_

Billing  
Names: \_\_\_\_\_  
(As indicated on IRS W-9 Form)

Billing Address: \_\_\_\_\_  
(As indicated on IRS W-9 Form)

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip \_\_\_\_\_  
(As submitted on claim form)

Remittance should be sent to where services are rendered?                       Yes     No

**I hereby certify that all of the responses and information provided pursuant to the above questions and requests included in this application are complete, true and correct to the best of my knowledge and belief and fully understand that any significant misstatements in or omissions from this application constitute cause for dismissal of appointment or cause for summary dismissal from the Network. If any material changes occur in the information provided in this application affecting my professional status, I understand and agree that it is my obligation to notify Sele-Dent, Inc. within five (5) business days of such occurrence.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

The following required information checklist is provided for your convenience.  
(FAILURE TO INCLUDE ANY OF THE FOLLOWING DOCUMENTS MAY RESULT IN A DELAY OR INACTIVATION OF YOUR APPLICATION!!!)

- A current state license/registration-signed by the applicant.
- A current federal DEA registration.
- A current state specific DEA or CDS registration, as required by the State in which you practice.
- A current Dental malpractice face sheet which includes the applicant's name, policy limits and limitations, the effective dates and the specialty(ies) of practice; if this is a group umbrella policy, please provide a document from the broker/carrier naming the applicant as insured.
- Hospital affiliation letters. You must still complete the application section even though you furnish these letters.
- Board Certification(s) (documentation with copies), if applicable.
- If you are Board Eligible, please submit proof of your Board Eligibility form from the Boards, or proof of completion of an approved Residency/Fellowship training program.
- A curriculum vitae (CV) or resume which accounts for all training and work/practice history since graduation from your professional school with an explanation for all gaps between training periods and/or jobs.
- 2 fully signed and dated agreements – See page 7.
- A fully signed and dated application – See pages 7 and 8.
- Academic appointments, if applicable.
- Copy of professional school diploma(s).

- Your TIN# (tax identification number)
- Your Social Security number.

I hereby authorize SELE-DENT, INC. and/or its designates to consult with hospitals, institutions, or healthcare organizations with which I have been associated and with others who may have information bearing on my professional competence, character, ethical qualifications, pending malpractice suits, judgments or settlements of a malpractice action or any finding of professional misconduct. I hereby further consent to the inspection by SELE-DENT, INC. and/or its designees of all documents that in their opinion may be material to an evaluation of my professional qualifications and competence, for utilization and quality assurance purposes, and to evaluate my moral and ethical qualifications for membership.

I hereby release from liability all representatives of SELE-DENT, INC. and/or its designees for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to SELE-DENT, INC. and/or its designees in good faith and without malice concerning my professional competence, ethics, character and other qualifications. I hereby consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of surgical-medical privileges and any other information which may be necessary to obtain in order to fulfill statutory and regulatory requirements to SELE-DENT, INC. and/or its designees or to hospitals where I may have applied for staff privileges.

I hereby further authorize SELE-DENT, INC. and/or its designees to communicate to hospitals, institutions and healthcare organizations with legitimate interest therein, any information concerning my professional competence, character, ethics and conduct, as well as any other information which must be disclosed in accordance with statutes and regulatory requirements that SELE-DENT, INC. and/or its designees may have to acquire, and, where such communication is made in good faith and without malice, I consent there to and agree to hold SELE-DENT, INC. and its authorized representatives and/or its designees free of liability therefore.

I hereby authorize my Dental Liability Insurance carrier to annually provide SELE-DENT, INC. and/or its designees with a copy of my Certificate of Insurance of Professional Liability Coverage (insurance holder) and updated claims experiences. In the event of any material change in, cancellation of, or failure to renew any professional liability coverage, I request and authorize SELE-DENT, INC. and/or its designees be given immediate written notice by any professional liability carrier. I hereby release my Dental Liability Company and its representative for the provision of such information to SELE-DENT, INC. and/or its designees.

A photocopy of this waiver shall be as effective as the original when so presented.

DATED: \_\_\_\_\_

NAME: \_\_\_\_\_  
(Please Print Name)

SIGNATURE: \_\_\_\_\_  
(No Signature Stamps Please)

**PLEASE ENSURE THAT THIS APPLICATION IS SIGNED ON PAGES 7 & 8**

# SELE-DENT, INC. GROUPS

## 10/1/2010

**1) Local 282 Retirees - Discount fee for service plan. According to Sele-Dent Fee Schedule. Member pays directly. Member pays Provider directly according to the Sele-Dent fee Schedule. Group#285**

**Local 282 Active** - Member is covered 100% of the Sele-Dent Fee Schedule. No deductible. \$2000 yearly max per covered individual. **Group#283**

**Local 282 Active-** Member is balance billed the difference between the Local 282 Fee Schedule and the Sele-Dent Fee Schedule. No Deductible. \$2000.00 yearly max per covered individual. **Group#284**

**2) Local 99/ Group 091,099,199** - \$1250 yearly max per covered individual. No deductible. 100% preventative 80% Basic & 60% Major. According to the Sele-Dent Fee Schedule. **Group 092 - \$2500 yearly max per covered individual (same breakdown as above)**

Any claim submitted over \$300 must be preauthorized.

**3) Local 381 Active** - No Max, No Deductible. Member pays Difference between the Sele-Dent Fee Schedule and the Local 381 Fee Schedule as co pay. Any claim over \$300 must be preauthorized. **Group # 107**

**Local 381 Retirees** - Discount fee for service plan. Member pays provider directly according to the Sele-Dent Fee Schedule. **Group #107R**

**4) Eastern Suffolk Boces Active and Retired** - \$1500 yearly max per covered individual. \$500 max for Perio/Ortho. No deductible. Member receives 100% Preventative 100% Basic 80% Major. According to the Sele-Dent fee schedule. **Group # 115**

**5) Local 2 PEG/IndIcom** - Discount fee for service plan. Member pays provider directly according to the Sele-Dent Fee Schedule. **Group # 102**

**6) Local 803 Actives F-** Member is covered 100% of the Sele-Dent Fee Schedule. There is a \$1500.00 yearly max per covered individual per calendar year. There is no deductible. Pre Authorizations for \$400.00 and up are required. **Group # 803**

**Local 803 Actives P-** Member is covered 100% of the Sele-Dent Fee Schedule. However, some procedures **are not covered by the Fund**. There is a \$500 yearly max per covered individual per calendar year. Pre Authorizations for \$400.00 and up are required. **Group #803**

**Local 803 Retirees R- Discount Fee for service plan only.** Member pays provider directly. **Group #803**

**Local 803 Actives GROUP #805 Discount Fee for Service only**

**7) Individuals-** Discount fee for service plan. Member pays provider directly according to the Sele-Dent Fee Schedule. **Group # 100**

# SELE-DENT, INC. GROUPS

## 10/1/2010

- 8) **NMDU (Newspaper Mail Deliver's Union)**- Discount fee for service plan. Member pays provider directly according to the Sele-Dent Fee Schedule. **Group # 103**
- 9) **Local 342 Insurance Trust Fund ILA**- Forward all claims to the Fund. Call the Fund directly for any claim and eligibility information. (631) 395-0600
- 10) **Cement & Concrete District Council** - Forward all claims to the Fund. Call the Fund directly for any claim and eligibility information. (718) 762-6133
- 11) **District 1199J New Jersey Benefit and Pension Fund** - \$1000 yearly max per covered individual. Member must pay co pay pertaining to the 1199J co pay Schedule. Provider will be reimbursed according to the Sele-Dent Fee Schedule less the 1199J copay. Any work for \$375 and up must be pre authorized. **Group # 119**  
**District 1199J New Jersey Benefit and Pension Fund Retirees**- Discount fee for service. Member pays provider directly according to the Sele-Dent fee schedule.
- 12) **Hauppauge Union Free School District** - \$1500 yearly max per covered individual. \$50 individual Deductible per calendar year and \$150 Family deductible per calendar year on **Basic and Major services only. Preventive is covered at 100%** of the Sele-Dent Fee Schedule. **All Basic and Major services are billed according to the Sele-Dent Fee Schedule. The difference between the Sele-Dent Fee Schedule and The Hauppauge UFSD Fee Schedule is balance billed to the member.** Any services of \$300 and up must be pre authorized. **Group#121**
- 13) **Local 947/Solo**- Discount fee for service plan. Member pays the provider directly according to the Sele-Dent Fee Schedule. **Group # 709**
- 14) **Levittown Fish Market**- Discount fee for service plan. Member pays the provider directly according to the Sele-Dent Fee Schedule. **Group # 715**
- 15) **Standard bred Owners Association**- Discount Fee for Service plan. Member pays the provider directly according to the Sele-Dent Fee Schedule. **Group #720**
- 16) **Riverhead Central Faculty Association** - \$1500.00 yearly max per covered individual.. There is no deductible and the plan covers 100% of the Sele-Dent Fee Schedule. **Group # 124**
- 17) **Allied Building Inspectors Local No. 211 I.U.O.E.** - \$1500.00 yearly max per covered individual. There is no deductible and the plan covers 100% of the Sele-Dent Fee schedule. Pre-Authorizations of \$350.00 or more is required. **Group # 211**

# SELE-DENT, INC. GROUPS

## 10/1/2010

- 18) **Teamsters Local 812 – Forward all claims to Teamsters Local 812 C/O Crossroads Healthcare Management at PO Box 090540 Staten Island, NY 10309.** Call Crossroads for any claim or eligibility information. **(800) 323-3165**
- 19) **Union Security Trust Fund Local 2682/ Hollow Metal Trust Fund/ Local 3127 - Forward all claims and eligibility questions to: C and R Consulting 1501 Broadway STE 1724 New York, NY 10036. (212) 869-5986**
- 20) **Local 713 - Discount Fee for Service plan. Member pays the provider directly according to the Sele-Dent Fee Schedule. Group #713**
- 21) **Sheet Metal Workers Local 38 - \$1500.00 yearly max per covered individual. There is a \$50 Individual deductible and \$150 Family deductible on Basic and Major only. The plan covers 100% of the Sele-Dent Fee schedule. Pre – Authorizations of \$500.00 and up are required. Claims must be sent to Maloney associates. Group #138**
- 22) **National Cleaners Association - Discount Fee for Service plan. Member pays the provider directly according to the Sele-Dent Fee Schedule. Group # 650,651,652**
- 23) **Allied Welfare Fund Local 338 Plan of Benefits - Forward all claims to the Allied Welfare Fund Local 338 Plan of Benefits C/O Crossroads Healthcare Management at PO Box 090300 Staten Island, NY 10309-0360. Call Crossroads for any claim or eligibility information. (866) 646-1778**
- 24) **IBT Local 854 Health and Welfare Fund:**
- a) **Group # 855 Plan 2 - \$15 copay per visit.** \$1000 maximum per covered person per calendar year. **No Deductible.** Fund covers 100% of the Sele-Dent Fee Schedule. Any claim over \$300 must be preauthorized.
  - b) **Group #856 Plan 3 - \$25 annual deductible per calendar year.** \$1500 maximum per covered person per calendar year. **No copay** Fund covers 100% of the Sele-Dent Fee Schedule. Any claim over \$300 must be pre authorized.
- 25) **Confederated Welfare Fund Local 2- Discount Fee for Service plan. Member pays the provider directly according to the Sele-Dent Fee Schedule. Group # 200**

# SELE-DENT, INC. GROUPS

## 10/1/2010

### 26) TPU Local No One NYC Stagehands:

- a) **Group #201-** 100% Sele-Dent Fee Schedule \$2000 maximum per covered person per calendar year. **There is no deductible or copay.** Any claim over \$500 is recommended for Pre-Authorization
- b) **Group #202-** 100% Sele-Dent Fee Schedule \$2000 maximum per covered person per calendar year. **There is no deductible or copay.** Any claim over \$500 is recommended for Pre-Authorization
- c) **Group #203-** 100% Sele-Dent Fee Schedule \$2000 maximum per covered person per calendar year. **There is no deductible or copay.** Any claim over \$500 is recommended for Pre-Authorization
- d) **Group #204(Welfare Fund of Local One)-** 100% Sele-Dent Fee Schedule \$2000 maximum per covered person per calendar year. **There is no deductible or copay.** Any claim over \$500 is recommended for Pre-Authorization

27) **CWA Local 1182 Security Benefits Fund-** \$1200 yearly maximum per covered individual.

28) **CWA Local 1183 Health and Welfare Fund-** \$3000 Family Maximum per calendar year. **No Deductible.** Member pays Difference between the Sele-Dent Fee Schedule and the CWA Local 1183 Health and Welfare Fund Fee Schedule as **co pay**. Any claim submitted over \$400 must be preauthorized **Group # 116**

29) **Retirees of CWA Local 1183 Health and Welfare Fund-** \$3000 Family Maximum per calendar year. **No Deductible.** Member pays Difference between the Sele-Dent Fee Schedule and the Retirees of CWA Local 1183 Health and Welfare Fund Fee Schedule as **co pay**. Any claim submitted over \$400 must be preauthorized **Group # 117**

30) **Union Mutual Medical Fund - Forward all claims to the to Syntonic Systems, Inc. at 80<sup>th</sup> 8 Avenue New York, NY 10011.** Call Syntonic Systems at (212) 989-8787 for any claim or eligibility information.

### 31) **International Union of Operating Engineers Local Union No. 94, 94A, 94B:**

- A) **Effective 6/1/10 -** \$2500 maximum per covered individual per calendar year. **No Deductible.** Member pays the difference between the Sele-Dent Fee Schedule and the Local 94 Fund Schedule. **IF SELE-DENT PROVIDER IS UNDER CONTRACT WITH THE LOCAL 94 NETWORK, THEN NO COPAYS APPLY.** Pre Authorizations is suggested for claims over \$500.

# SELE-DENT, INC. GROUPS

## 10/1/2010

32) **Special and Superior Officers Benevolent Association Welfare Fund – (SSOBA)** \$1500 maximum per covered individual per calendar year. Member pays the difference between the Sele-Dent Fee Schedule and the SSOBA Fund Schedule. No Pre-authorizations required. **Group# 540 & #541**

33) **UPSE Hauppauge Benefit Plan** - \$2000 maximum per covered individual per calendar year. The plan covers 100% of the Sele-Dent Fee schedule. **There is no deductible or copay.** Any claim submitted over \$250 must be preauthorized. **Group #410**

34) **Local 107 Management Trust Fund** –Discount Fee for service only. Member pays provider directly after services are rendered. **Group #207**

35) **New York City District Council of Carpenters** - Pays 100% of the **NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS FEE SCHEDULE**. This schedule is different than the general Sele-Dent Fee Schedule. If your office does not have the **NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS SCHEDULE**, please call our office @ (800) 520-3368. The maximum for this group is as follows:

**\$2500 Maximum** - 1) Active 2) BCA 3) CEME 4) City 5) Cobra 6) FCA 7) MWA 8)WCCA 9) Disabled **Group # 232**

**\$1500 Maximum** - 1) Retiree 2) Widow **Group # 233**

All groups have a \$100 deductible on Basic and Major. There are co-pays on implants only. There is no deductible on preventative. Pre Authorizations are suggested.

36) **Sheet Metal Workers Local Union 28** – Pays 100% of the Sele-Dent fee schedule. **Copays apply on certain procedures. There is no deductible.** Pre Authorizations on major work \$325 and up are mandatory.

**\$1000 Maximum** – Per covered individual per calendar year. Sheet metal workers group **#028**

**\$500 Maximum** – Per covered individual per calendar year. Production workers group **#029**

37) **Rockville Centre Teacher's Association** - \$2100 Family Maximum. **Member pays provider the Sele-Dent, Inc. rate directly at time of service.** Provider submits claim form on member's behalf in which payment will go to member. **#126**

# **SELE-DENT, INC. GROUPS**

## **10/1/2010**

38) UPSE Town of Ilsip Blue Collar Workers - \$1700 maximum per covered individual per calendar year. The plan covers 100% of the Sele-Dent Fee schedule. **There is no deductible or copay.** Any claim submitted over \$250 must be preauthorized.  
**Group #411**

**\*ANY ROOT CANALS, POST AND CORE, CROWNS AND BRIDGEWORK,  
PLEASE SUBMIT X-RAYS.**

Please complete & return.  
to FAX 516 887-7896

Form **W-9**  
(Rev. November 2005)  
Department of the Treasury  
Internal Revenue Service

**Request for Taxpayer  
Identification Number and Certification**

Give form to the requester. Do not send to the IRS.

Print or type  
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box:  Individual/Sole proprietor  Corporation  Partnership  Other  Exempt from backup withholding

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

City, state, and ZIP code

List account number(s) here (optional)

Requester's name and address (optional)  
**Sele-Dent, Inc.**  
**381 Sunrise Hwy, Suite 307**  
**Lynbrook, NY 11563**

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

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or

Employer identification number

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**Part II Certification**

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. person (including a U.S. resident alien).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

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

**Purpose of Form**

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,