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Website: https://www.ddsinc.net
Email: Jeanne@ddsinc.net

ADDING A PARTICIPATING PROVIDER TO LOCATION(S)

FOR EACH LOCATION LISTED UNDER THIS PRACTICE

(Any additional locations with a different Tax ID must be affiliated with same practice/group & listed on this page, dental agreement & List of Union pages).

DATE: _____

PROVIDER NAME: _____ TYPE/SPECIALTY: _____

PROVIDERS NPI: _____

TAX ID(s): _____

-List ALL Tax ID's associated with agreement

LOCATION NAME: _____ TAX ID: _____

LOCATION ADDRESS: _____

LOCATION NAME: _____ TAX ID: _____

LOCATION ADDRESS: _____

LOCATION NAME: _____ TAX ID: _____

LOCATION ADDRESS: _____

LOCATION NAME: _____ TAX ID: _____

LOCATION ADDRESS: _____

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LOCATION NAME: _____ **TAX ID:** _____

LOCATION ADDRESS: _____

LOCATION NAME: _____ **TAX ID:** _____

LOCATION ADDRESS: _____

LOCATION NAME: _____ **TAX ID:** _____

LOCATION ADDRESS: _____

LOCATION NAME: _____ **TAX ID:** _____

LOCATION ADDRESS: _____

LOCATION NAME: _____ **TAX ID:** _____

LOCATION ADDRESS: _____

LOCATION NAME: _____ **TAX ID:** _____

LOCATION ADDRESS: _____

As per your request, DDS Inc. will add this provider as a participating provider under the above Tax ID number(s) to ALL PLANS these locations are participating with. I agree to accept the union fee schedules as payment in full for all covered services, up to the limits of the plan for ALL PLANS these locations participate with.

List of Union Participation for this TAX ID-ALL LOCATIONS is attached.

Providers Signature: _____ **Date:** _____

Print Name: _____

DDS inc.

DDS CODE									
TAX ID/ LOCATION									
UNION/ LOCALS									
ALL Unions									
3									
8A28A									
17-18									
22									
25 A/B									
30-M/P									
97									
108									
138									
175									
L210									
259									
295									
298-1/2									
338									
363-A									
363-E									
475									
485									
514									
670									
707									
713									
805/810									
813									
1010									
1042									
1102-ALL									
1175/11751									
1181									
1199									
1298									
1500									
AIHF									
AWF									
BCTGM									
BLDG									
CAA									
JIB/JIBE									
RENAI									
R108									
TYP6									
UEHP									
UWHF									

I affirm my participation with the indicated unions/groups (checked off plan participation)

Signature of Provider:_____ **Date:** _____

Printed Name: _____ **Tax ID (S):** _____

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OFFICE USE ONLY

Location #: _____

Tax Id #: _____

Location NPI #: _____

Effective Date: _____

DENTAL AGREEMENT

I HEREBY AFFIRM AND REPRESENT THAT ALL STATEMENTS, ANSWERS, AND INFORMATION CONTAINED IN THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I UNDERSTAND THAT BY SIGNING UP WITH D. D. SERVICES, INC., I MUST ACCEPT FULL OR PARTIAL PAYMENTS AS PER EACH FEE SCHEDULE.

I WILL ACCEPT AN "ALTERNATIVE BENEFIT" FOR A SPECIFIC SERVICE, IF AVAILABLE AND APPLY THAT TO SERVICE ON THE CLAIM.

IF A PATIENT SERVICE IS DENIED DUE TO A FREQUENCY LIMIT; I WILL ACCEPT PAYMENT AS PER THE FEE SCHEDULE

IF A PATIENT EXCEEDS THEIR MAXIMUM, I WILL CONTINUE TO ACCEPT PAYMENTS AS PER FEE SCHEDULE.

FOR THOSE GROUPS THAT HAVE DEDUCTIBLES: I MUST ACCEPT PAYMENTS AS PER FEE SCHEDULE UNLESS THE SERVICE EXCEEDS THE DEDUCTIBLE.

WHEN A CLAIM IS SUBMITTED INCORRECTLY OR PROCESSED INCORRECTLY

I WILL ACCEPT TO REFUND DDS, INC. FOR ANY PROCEDURE THAT HAS BEEN PROCESSED INCORRECTLY EITHER BY DDS, INC. PERSONNEL OR BY MY OFFICE. UPON RECEIPT OF THE REFUND, THE CLAIM WILL BE PROCESSED AGAIN.

PRE-AUTHORIZATION PROCEDURE

If the treatment exceeds $300.00 then the claim form and the patient's x-rays must be sent to address of DDS, Inc. for pre-authorization.
Pre and Post Op x-rays are required on all unauthorized work.

PHI CLAUSE

The Provider agrees to implement and use appropriate administrative, technical, and physical safeguards to protect the confidentiality, integrity and availability of PHI and EPHI that it creates, receives, maintains or transmits.

UNION ID CARDS & PHOTO ID

I agree to obtain a copy of the patient's union card (issued by the union} and/or a photo ID as proof of their identity and will retain a copy in each patient's chart. Minors without a union card or photo ID, the dental location shall retain a copy of the parent or guardian's photo ID.

FURTHER AGREE THAT I WILL NOTIFY D.D.SERVICES, INC. IF ANY OF THE REPRESENTATIONS IN THIS AGREEMENT CEASES TO BE TRUE OR CHANGES AT ANY TIME WHILE THIS AGREEMENT IS IN EFFECT. I AGREE TO PROVIDE AT LEAST 30 DAYS NOTIFICATION IN THE EVENT I ELECT TO TERMINATE THIS AGREEMENT AND TO FINISH ANY CASES THAT HAVE BEGUN WHILE THIS AGREEMENT WAS IN EFFECT. ANY PRE-AUTHORIZATIONS THAT HAVE BEEN APPROVED PRIOR TO TERMINATION OF THIS AGREEMENT WILL BE HONORED AS PER THE FEE SCHEDULE.

_____ _____

SIGNATURE of PROVIDER *DATE*

_____

PRINT NAME

_____

TAX ID (S) # (Please list all Tax ID numbers for multiple Locations)

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Credentialing Packet for each individual Provider

Provider Name: _____ DDS DMD OTHER (PLEASE CIRCLE ONE)

Provider NPI: _____

Provider Email: _____

Credentialing Email: _____

Provider Address: _____

_____

Provider Type/Specialty: _____

Are you "American Board Certified" in any of the below Specialties: ***if yes, please circle the applicable board***

ABO-ORTHODONTIST ***ABOMS-ORAL SURGEON*** ***ABP-PROSTHODONTIST*** ***ABPD-PEDIATRIC DENTIST***

ABE-ENDODONTIST ***ABP-PERIODONTIST***

Do you have a current license or permit to administer conscious sedation/general anesthesia? ***(Please circle one)***

Yes or No

If yes: (Please circle one & fill in required information)

Type: IV Sedation General Anesthesia Permit # _____ Expiration Date: _____

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Dental License #: _____ Expiration Date: _____

Specialty License #: _____ Expiration Date: _____

Insurance Company Name: _____ Expiration Date: _____

Insurance Type: _____ Policy #: _____

DEA Certificate #: _____ Expiration Date: _____

If you do not have a DEA Certificate or not renewing DEA, please attach a waiver

Medicare #: _____ Medicaid #: _____

Dental School: _____ Year Graduated: _____

Specialty School: _____ Year Graduated: _____

Important Disclosure to avoid delays in processing of any claims

Please attach a copy of the provider's Dental License, Insurance Declaration Page, DEA Cert. or Waiver of DEA, Specialty License-if applicable and CV when submitting this form. We must retain a current copy of all the above listed items. Upon renewal, please email us the updated copies as soon as you receive them. You may email the renewals only to: Support@ddsinc.net

Please attach a detailed explanation of any professional disciplinary actions and/or unprofessional misconduct, lawsuits, arbitration, settlements, and/or pending cases or judgements, as well as for any absence/gaps of License or Insurance.

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Professional Attestation and Questions

In the past 10 years

- Has your license to practice in any jurisdiction, whether past or still pending, been denied, restricted, limited, suspended, revoked, not renewed, placed under probation, subject to disciplinary or non-disciplinary action or otherwise sanctioned, limited or curtailed? **YES or NO**
- Has your professional liability insurance ever been denied, suspended, revoked, canceled or not renewed? **YES or NO**
- Has your Federal and/or State DEA license or applicable drug license ever been denied, suspended, canceled or not renewed or subject to any disciplinary actions? **YES or NO**
- Has your status as a dentist ever been denied, suspended, canceled or sanctioned by any municipal, state, federal or any governmental agency or other health plan? **YES or NO**
- Have you ever been denied membership or renewal of membership or been subject to disciplinary proceedings for a medical, dental or ethical reason by any dental/professional organization? **YES or NO**
- Are you unable to perform any procedures within the cope of privileges and duties in your position as a health care dentist, with or without reasonable accommodations required by the Americans with Disabilities Act, within accepted standards of professional performance and without posing a direct threat to patients? **YES or NO**

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- Do you have any felony or misdemeanor charges pending against you or have you ever been convicted of a felony, or pleaded “nolo contendere” to a felony?

  YES or NO

- Have you been involved in ANY malpractice or Civil claims/lawsuits, settlements, judgements within the last 10 years? If yes, please provide detailed information on a separate sheet of paper. **YES or NO**

- Do you have current professional malpractice insurance coverage ad agree to maintain continuous, uninterrupted coverage while either a contracted dentist or an associate of a contracted dental dentist? **YES or NO**

I authorize the Credentialing Department to consult with professional liability carriers and other persons or entities to obtain information concerning my professional qualifications including competence, ethics and other qualifications. I, the undersigned, hereby certify that the information requested by D.D. Services Inc. and provided herein, is truthful, correct and complete in all respects. I further understand that the intentional submission of false, misleading information or withholding of relevant information is grounds for denying participation or termination as a contracting dentist with D.D. Services Inc.. The undersigned hereby agrees to notify us immediately of any changes immediately.

I authorize receiving communication electronically.

Dentist Signature: _____ Date: _____

Dentist Name: _____

Dentist NPI: _____

Updated 3-13-26