DDS

inc.

Dental Plans
265 Post Avenue, Ste. 340
Westbury, NY 11590
(516) 794-7700
Fax (516) 794-7762
email: carol@ddsinc.net

Name of Dental Location: _____
Address of Location: _____
_____

Tax #: _____ **Provider** _____

Dear Dr.,
This is to confirm your request to **add** a DOCTOR as participating with DDS, Inc. to your office location using same Tax ID # ,for the unions your office participates with: ***ALL UNIONS THIS LOCATION PARTICIPATES WITH.***

Please mail or fax to my attention this letter of agreement, current license, DEA, current insurance policy! Accept this as your confirmation of participation.
Please feel free to call me if you have any questions or comments.

Sincerely,
Carol Marando

Carol Marando
Provider Relations Coordinator
Date: _____

I agree to accept the above listed union fee schedules listed above as payment in full for all covered services, up to the limits of the plan.

NAME_____PHONE#_____

ADDRESS_____CITY/ST/ZIP_____

COUNTY_____FAX # _____

DATE_____TYPE/SPECIALTY_____

TIN # _____ EMAIL _____
(required)

Signature_____ Individual NPI#_____(required)

PLEASE INCLUDE THE ACTUAL COPIES OF DOCTOR'S CREDENTIALS WHEN RETURNING THIS FORM

LICENSE # _____ST ____ License Expiration Date:_____

DEA REGISTRATION NUMBER: _____ Expiration Date: _____

BOARD CERTIFIED? ( ) Y/N If Yes, send copy of Board Certification School Attended: _____

INSURANCE: _____ Insurance Expiration Date: _____

INSURANCE POLICY #: _____Medicare #: _____

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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 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 WILLACCEPT 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.

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 DOCTOR DATED

PRINT NAME: _____

ADDRESS : _____

CREDENTIAL FORM

Dental Location: _____

Address of Location: _____

Return with copies of all of the following

LICENSE

DEA

INSURANCE

INDIVIDUAL NPI

SCHOOL ATTENDED

BOARD CERTIFICATION(if applicable)

Please complete the following

NAME _____ Specialty _____

INDIVIDUAL NPI # _____

DENTAL SCHOOL GRADUATED FROM: _____ (send copy)

LICENSE # _____ ST ____ License Expiration Date: _____

DEA REGISTRATION NUMBER: _____ Expiration Date: _____

INSURANCE: _____ Insurance Expiration Date: _____

INSURANCE POLICY #: _____

BOARD CERTIFIED? ( ) Y/N If Yes, send copy of Board Certification
Please make sure you indicate Yes or NO

BOARD ELIGIBLE? ( ) Y/N If yes, send copy of Letter

MEDICARE/MEDICAID PARTICIPATION: _____

If chose Non-Par with Medicare/Medicaid: If possible, please send PROOF of OPTED OUT of this program (required)

Dr. Signature: _____

Please send history of professional disciplinary actions and/or unprofessional misconduct for any absence of License or Insurance. Any absence of history of lawsuits, arbitration, settlements and/or pending cases or judgments

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TO ALL DDS PARTICIPATING DOCTORS

Dear Dr.,
Please be advised we are asking all of our doctors if they have the ability to service patients with "special needs." It has been brought to our attention and would like to list your office location on our referral list if you have a doctor that can service these patients.

Sincerely,
Carol Marando

Carol Marando
Provider Relations Coordinator
September 10, 2019

☐ I have the following doctor who services patients with "special needs"

- ⬭ Services All Needs
- ⬭ Handicap Accessible
- ⬭ Or list the services your location does have

☐ I do NOT have a doctor in my location: Tax ID#: _____

_____
NAME

_____
ADDRESS

_____ Specialty_____
COUNTY

_____ Group NPI #: _____
SIGNATURE

DATE_____PHONE #_____

FAX #_____SS # / TIN # _____
(REQUIRED)