

Application Tutorial



In order to quickly process your application, it is important that all forms are completed fully and accurately. The following pages address our most frequently asked questions.

- W-9 form
- Office information sheet
- Provider service agreement
- Credentialing information form
- Attestation (questionnaire)
- Other documentation

Thank you!

W-9 Form



- Legal name – must match the legal name on file with TIN at the IRS (must also match the office’s legal name on Office Information Sheet)
- Type of business
- Tax ID owner’s signature / Date
- Address (where claims should be sent)
- Multiple offices
- Indicate whether the number provided is an EIN or SSN (SSN cannot be used for multiple dentists)

W-9 Request for Taxpayer Identification Number and Certification

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

Contact name, if different from above

Address (street, city, state, and zip or state only) Individual Partnership Other Requester's name and address (optional)

State and ZIP code

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. If you are a U.S. person (including a U.S. resident alien), you are generally subject to backup withholding because you have failed to report all interest and dividends on your tax return. For most other filers, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, disposition of stock, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign this Certification, but you must provide your correct TIN. See the instructions on page 1.

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 you are subject to backup withholding as a result of a failure to report all interest and dividends, or (c) the IRS has notified me that I am not subject to backup withholding, and
- I am a U.S. person (including a U.S. resident alien).

Certification instructions: This must certify that you are a U.S. person and that you have been notified by the IRS that you are generally subject to backup withholding because you have failed to report all interest and dividends on your tax return. For most other filers, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, disposition of stock, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign this Certification, but you must provide your correct TIN. See the instructions on page 1.

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, non-employee compensation, mortgage interest you paid, acquisition or abandonment of secured property, contribution of stock, or contributions you made to an IRA.

U.S. persons. Use Form W-9 if you or you see 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 you are not subject to backup withholding.

Foreign persons. If you are a foreign person, do not use Form W-9 to request a TIN. Instead, use the appropriate Form 1042-R if you are a foreign person who is a U.S. resident alien. If you are a U.S. resident alien, you may be eligible for an exemption from tax on certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes. If you are a U.S. resident alien who is waiting on an exemption contained in the taxing clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following tax treaty:

- The treaty country, country, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
- The treaty article addressing the income.
- The article number or location in the tax treaty that contains the taxing clause and the exemption.

Form W-9 (Rev. 1-2010)

Office Information Sheet



- Legal name (must match the office's legal name on W-9)
- Tax ID
- Owner's name
- Address / Phone #
- Provider box
- Misc. office info
- Owner's signature / Date

DENTEMAX 800.732.1547

PLEASE CHECK THE APPROPRIATE BOX:
 I am adding a provider
 I am adding a location
 I am changing my address
 I am changing my Tax ID

Dental Office Information Sheet

Dentemax contracts according to Tax Identification Number (TIN). All doctors and locations associated with a participating TIN are considered to participate with Dentemax. Therefore, please complete a Dental Office Information Sheet for EACH location associated to the participating TIN. Please complete a Provider Service Agreement, a Dental Application and a Professional Questions and Attention for EACH doctor associated to the participating TIN.

Participating Dental Office Information

CPSC Name (Legal Name) _____ Checked for Claims

CPSC Name (As it should appear in the Provider Directory if different) _____ Provider's Name

Street Address _____ Suite Number _____ Email Address _____

City _____ County _____ State _____ Zip Code _____ Contact Person at this Location _____

Telephone Number _____ Fax Number _____ Contact Person's Title _____

Please list all providers at this location. A Provider Service Agreement, Dental Application and Professional Questions and Attention must be completed for each provider.

Miscellaneous Office Information

Office Hours (include evenings and weekends)

Day	Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Office hours		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After hours emergency coverage		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe your after hours emergency coverage: _____

Is your office bilingual? Yes No If yes, what language? _____

Is your office accessible to physically disabled? Yes No

Does your office meet OSHA and CDC standards and guidelines? Yes No

Are you prepared for a medical emergency? Yes No

Do you have a medical emergency kit? Yes No

Do you have portable oxygen with positive pressure? Yes No

Is someone in your office CPR certified? Yes No

Do you have properly functioning fire equipment, including fire extinguishers, fire alarm, and fire escape? Yes No

Do you have an organized patient charting and recall system? Yes No

Insurance identification types: Cash Medicare Medicaid Other _____

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I acknowledge that all office information contained in this application is accurate, complete and truthful to the best of my knowledge. I agree that I will provide written notification to Dentemax of any material change to the above. I understand that I have the right to review and correct any information on the undersigned process.

Signature _____ Date _____

Signed Agreements, information sheets and any supporting documentation should be sent or faxed to:
Dentemax Provider Relations
 2858 Northwestern Highway, Suite 450 • Southfield, MI 48034 • Fax: 248.327.8001

Provider Service Agreement



- Signature / Date
- Address (must match address on the Office Information Sheet)
- Copy quality (if copied or faxed, please ensure document is clear and readable)

Dentemax Provider Service Agreement

This agreement is between Dentemax, and the Provider, _____, a duly licensed dentist, or a recognized entity to provide dental services in the state of _____.

Dentemax is the owner and manager of a Preferred Provider Network which gives Participants access to its Providers through various individual and/or group dental plans.

The Provider desires to perform dental services for the Participants of the Dentemax program.

In consideration of the mutual promises contained herein, the parties agree as follows:

Definitions

Network shall mean Preferred Provider Network of dentists who, as Providers, have a contractual relationship with Dentemax to provide dental services under Dentemax established policies.

Provider shall be the owner of the tax identification number, or their duly authorized agent, and all other employees and/or independent practitioners of this entity who are licensed to practice dentistry in accordance with current laws.

Payor shall mean an employer, administrator, insurance carrier, fund, individual or other entity who is responsible for the payment of the claim.

Participant shall mean persons who through a dental plan with the Payor or by some other contractual relationship with Dentemax, are eligible to use the Network for dental care.

I. Responsibilities of Provider

- Provider agrees to meet the requirements of the Dentemax Fee Schedule, or the provider's usual fee if less, as full consideration for dental services provided to Participants. Provider agrees not to bill patient for the balance between the Dentemax fee and the provider's usual charge. Higher The Participant may be responsible for any treatment such as copayments, deductibles, and amounts exceeding the benefit maximum.
- Provider agrees to meet Dentemax Participants as they would any other patient in their practice.
- Provider is responsible for ensuring the quality and benefit coverage of their Patients.
- Provider agrees to agree to the guidelines established by the Payor to claim review and payment. Provider agrees to cooperate and furnish any material or information requested by the Payor or Dentemax required for claim payment and/or claim review.
- Provider acknowledges that Dentemax is not liable for any payments due to the Provider including but not limited to the claim Payor or the Participant.
- Provider agrees to accept and be responsible for their own acts or omissions in the professional practice of dentistry as well. Nothing in this agreement shall be interpreted or construed to place any such responsibility for professional acts or omissions on Dentemax.
- Provider agrees to promptly notify Dentemax in writing of any change in status regarding licensure, insurance coverage or other material facts related to the information provided.

II. Responsibilities of Dentemax

- Dentemax shall provide administrative and management duties in the development and maintenance of the Network.
- Dentemax shall market its program group and individuals with the intent of obtaining Participants who may become patients of the Provider.
- Dentemax is authorized to disseminate information about the Network to the Dentemax Provider Network, on the Dentemax website or other publications.
- Dentemax shall have the right to amend this agreement by providing written notice. Failure of the Provider to reasonably object within thirty days of Dentemax sending the terms shall constitute acceptance.
- Dentemax agrees to accept and be responsible for its own acts or omissions, as well as those of its employees, and nothing in this agreement shall be interpreted or construed to place any such responsibility on the Provider.

III. General Provisions

- This Agreement, the attached information sheet and dental applications represent the entire agreement between the parties and supersedes all previous agreements, whether written or oral, between Dentemax and Provider.
- Some states require separate contracts when provided by reference to the attached Schedule. If there is a conflict between provisions in the state law that law prevails.
- Some states require separate contracts when provided by reference to the attached Schedule. If there is a conflict between provisions in the state law that law prevails.
- This Agreement shall be effective when the provider has signed, countersigned and are entered into the Dentemax Provider Database. The effective date of these additions shall be the earlier of the 15th day or last day of the month in which the change is made. This Agreement shall remain in effect and amended unless written notice of either party, with a verbal notice. Provider termination will be effective the first day of the month in which they are received.
- Dentemax and Provider agree that each party is independent from the other and that the provisions of this agreement do not create an employer-employee relationship between the parties.
- All notices, including but not limited to change of address and change of license status shall be submitted in writing and delivered either personally or by U.S. Mail postage prepaid to the address below or any new address supplied by the other party.
- This Agreement may be assigned only by Dentemax.
- This Agreement may be governed by the laws of the State of Michigan.

Provider Signature _____ Date _____

City _____ State _____ Zip _____

Address _____

Dentemax
 2858 Northwestern Highway, Suite 450
 Southfield, MI 48034
 800.732.1547 Fax: 248.327.8001

Other Documentation



Please provide copies of the following documents:

- Current malpractice insurance
- Current DEA or CDS (if applicable – not required for Orthodontists or Pediatric Dentists)
- Current state dental license
- Specialty certificate (if applicable)
- CV / Resume (covering 5 years or back to graduation date – whichever comes first)

Questions?



Thank you for your interest in the DenteMax network!

If you have any questions, please contact us at [1-800-752-1547](tel:1-800-752-1547).

You will be automatically connected to a live representative during normal business hours (Monday – Thursday 8:15 am to 7:00 pm EST, Friday 9:00 am to 4:45 pm EST).

You may also e-mail us at customerservices@dentemax.com

www.dentemax.com