Dentist Participation Agreement
State Dental Plan
State of Minnesota Preferred Provider Organization (PPO)

I hereby apply to Delta Dental® of Minnesota (a non-profit health service plan corporation hereinafter referred to as DDMN) to become a participating dentist in the State of Minnesota's PPO dental network hereinafter know as the State Dental Plan (SDP) administered and maintained by DDMN. In consideration of this participation, I represent and agree as follows:

1. I, ________________________, am duly licensed to practice dentistry in the State of _______________, having been issued License Number ________________, represent that my license is in good standing, and no disciplinary proceedings are pending against me.
2. I will be bound by DDMN's authorized rules, regulations, policies and procedures as adopted and amended from time to time by the DDMN Board of Directors.
3. Any dental service I render to SDP eligible subscribers and their covered dependents shall be in accordance with applicable laws and the SDP as adopted and amended from time to time by DDMN.
4. DDMN's payments for SDP will be based on my usual fees pre-filed with DDMN, the fee actually charged, or the SDP fee table maximum as determined by the State of Minnesota, whichever is less.
5. I will accept SDP allowance on submitted claims as payment in full and will not balance bill any amount to SDP patients except for contract deductibles, co-payments and non-covered services.
6. I understand that acceptance and continued participation in SDP is subject to utilization review criteria as established by DDMN.
7. In providing or rendering dental services under this Agreement, I or any person, acting under my direction and control, shall be an independent t contractor and not an agent or employee of DDMN. DDMN shall not be liable for any wrongful acts and I agree to indemnify and hold DDMN harmless for any liability therefore.
8. This Agreement is not assignable by me without DDMN's prior written consent.
9. I may examine processed claims by appointment at Delta's office during normal business hours upon reasonable notice.
10. This Agreement may be terminated by either party by providing not less than ninety (90) days written notice to the other party at the last known address of record.
11. I shall keep records as are necessary to fully disclose the extent of the services provided to individuals under SDP and I will furnish DDMN all information regarding this program as may from time to time be requested.
12. I understand that a signed and active DDMN Premier Dentist Membership and Agreement is required for participation in the SDP.
13. I agree this Agreement applies to all locations where I practice.
14. I agree to comply with any state laws regarding participation in Minnesota Health Care Programs.

DENTIST PRACTICE INFORMATION**

Date	Signature (of Individual Dentist)
Printed or Typed Name	Phone Number
Office Name (If Office)	Fax Number
Mailing Address	

City State Zip Code National Provider Identifier Number (NPI)

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**** Dentists who practice at more than one location should provide the Dentist Practice Information for other locations on a separate document and attach it to this application.**