DELTA DENTAL®

DENTIST PARTICIPATION AGREEMENT
Delta Dental Medicare Advantage

Delta Dental of Minnesota Professional Services Dept.
500 Washington Ave S, Suite 2060
Minneapolis, MN 55415-1163
Phone: (651) 406-5900, Toll Free (800) 774-9049

In consideration for Delta Dental of Minnesota's (a non-profit Minnesota health service plan corporation, hereinafter referred to as DDMN) agreement to include me as a provider for the Medicare Program (as such term is defined in the Delta Dental Participating Dental Provider Policies and Procedures) administered by DDMN for members of Medicare Programs, I represent and agree that:

A. I,_____, am duly licensed to practice dentistry in the State of_____, having been issued License No._____, that my license is in good standing, and that no disciplinary proceedings are pending against me.

B. I am not currently opted out of the Medicare Program, nor am I currently listed on the CMS Preclusion list.

C. The term of this Agreement shall commence on the date signed below and shall continue and remain in effect until terminated.

D. I understand that to qualify for participation in this network, I must have a current Minnesota Select Dental℠ Participation Agreement with DDMN.

E. DDMN or I may terminate this Agreement, without cause, upon at least sixty (60) days prior written notice to the other party. "Cause" is defined as material breach of this Agreement. In addition, this Agreement will terminate immediately and automatically upon termination of my Minnesota Select Dental℠ Participation Agreement.

F. I will be bound by all state, federal and local governmental laws, rules and regulations applicable to the treatment of Medicare members (including Medicare laws and regulations and CMS instructions in the provision of covered services), as well as all DDMN rules and regulations including but not limited to the Delta Dental Participating Dental Provider Policies and Procedures.

G. I shall make every reasonable effort to provide Medicare Programs' covered services in a culturally competent manner to all members, including those members with limited English proficiency or reading skills; diverse cultural and ethnic backgrounds, and physical and mental disabilities.

H. I shall provide Medicare Program members with timely access to covered services and shall comply with procedures established by DDMN to monitor the provision of covered services to ensure compliance with Centers for Medicaid and Medicare Services (CMS) standards.

I. I shall not discriminate against any person based on his or her race, color, religion, national origin, gender, marital status, status with regard to public assistance, disability, sexual orientation, age, physical or mental status, gender status or any other classification protected by law.

J. Payments made for services rendered by me, under this Agreement, to Medicare Program members may be, in whole or in part, from federal funds.

K. I agree not to bill, charge, collect a deposit from, seek remunerations from, or have any recourse against any member or persons acting on his or her behalf for services provided under this Agreement. This provision applies to, but is not limited to, the following events: (1) nonpayment by DDMN, (2) insolvency of DDMN, or (3) breach of this Agreement. This provision does not prohibit me from collecting co-payments, coinsurance, deductibles or fees for uncovered services.

This provision shall be construed in favor of the member and shall survive the termination of this Agreement for services provided before this Agreement terminates, regardless of the reason for termination. *This provision supersedes any contrary oral or written agreement entered into between me, DDMN, the member or persons acting on his or her behalf regarding liability for payment for services provided under this Agreement.*

In the event of DDMN's insolvency, I shall continue to provide covered services to any member covered under a Medicare Program for the duration of the contract period for which CMS payments have been made for such members.

L. I shall certify, in writing, the completeness and accuracy of all dental services. I will cooperate with DDMN to address any inquiries from CMS regarding the accuracy of data submitted pursuant to this Agreement. I will indemnify DDMN for any penalty or fine assessed by CMS against DDMN, resulting from proven inaccuracy of data I submitted for Medicare Program members.

M. I will accept the lesser of my submitted charge and maximum allowed amount determined by DDMN and the Medicare Health Plan as payment in full for covered services.

N. DDMN may seek monetary recovery, notify the Department of Human Services, CMS, and Medicare Advantage Organization (MAO) or impose administrative sanctions on ay provider for abuse or fraud identified.

O. DDMN will comply with applicable prompt payment requirements under state and federal law.

By signing this agreement you hereby agree to participate in the Delta Dental Medicare Advantage network operated by Delta Dental of Minnesota.

Submitted this_____day of_____, year of_____.

Signature | Specialty, if any | Soc. Sec./Tax ID No.

Mailing Address | Phone

City | State | Zip code | County

**Delta Dental of Minnesota is an authorized licensee of the Delta Dental Plans Association of Oak Brook, Illinois.*