# PRACTICE INFORMATION AND LETTER AGREEMENT FORM

COMPLETE, SIGN AND RETURN TO: One Huntington Quadrangle Suite 1N09 Melville, NY 11747

## PERSONAL DATA

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>License Number</th>
<th>Tax I.D. Number for Insurance Billing</th>
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<thead>
<tr>
<th>Address</th>
<th>Suite No.</th>
<th>City</th>
<th>Date of Birth</th>
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<tr>
<th>State</th>
<th>Zip</th>
<th>County</th>
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<tr>
<th>Telephone</th>
<th>Emergency</th>
<th>Fax</th>
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<td>Office ( )</td>
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<thead>
<tr>
<th>Dental School</th>
<th>Degree</th>
<th>Year Graduated</th>
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[ ] General Practice  [ ] Specialty

[ ] Board Eligible  [ ] Board Certified

Do you limit your practice to your specialty [ ] Yes [ ] No

Post Graduate Courses (Dates & Description)

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Professional Organizations

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List other dental panels which you are a member of

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OFFICE USE ONLY
PARTICIPATING PROVIDER APPLICATION

(Please type or print clearly and complete all sections of application.
Use N/A for not applicable. Leave no blanks.

________________________________       __________________________________       ___
_______________________________       __________________________________       ___
(Last Name)                                          (First Name)                              (M.I.)
Date of Birth ______/______/______     [  ] Male   [  ] Female    SS#_______________________
Mo.    Day    Year
Are you applying as a [ ] Primary Care Provider  [ ] Referral Specialist  [ ] both
Are you accepting new patients?   [ ] Yes   [ ] No
If yes, do you have any practice limitations?   [ ] Yes   [ ] No
If yes, specify________________________________________________________
____________________________________________________________________________________
Do you accept Worker’s Comp. Patients?   [ ] Yes   [ ] No   Workers Comp. #_____________
Medicaid #:______________________________

I. CREDENTIALS AND WORK HISTORY

FULL NAME OF INSTITUTION     CITY, STATE     DATES     DEGREE

Undergraduate School

____________________________________________________________________________________

Dental School

____________________________________________________________________________________

Other (including residency, fellowship, training and professional work history)

____________________________________________________________________________________

Teaching appointments_______________________________________________________________
____________________________________________________________________________________

Professional Society and Civic Association Memberships____________________________________
____________________________________________________________________________________

Please attach a copy of our curriculum vitae (CV) which includes prior hospital affiliations and employers.

Board Certified?   [ ] Yes   [ ] No   Year_______   Expiration_______   Board Eligible?   [ ] Yes   [ ] No
Board Eligible until________________________

2 of 10
If Board Eligible, expected exam date(s)? ___________________________________________________________

Please attach copies of Board Specialty Certificates.

<table>
<thead>
<tr>
<th>Primary State of Licensure</th>
<th>License No.</th>
<th>Expiration Date</th>
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<td>_________________________</td>
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<tr>
<th>Secondary State of License</th>
<th>License No.</th>
<th>Expiration Date</th>
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<tr>
<td>_________________________</td>
<td>_______</td>
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Please attach signed copies of your license(s).

Federal DEA Number________________________________________ Expiration Date____________________

State DEA/CDS Number________________________________________ Expiration Date____________________
Please attach copies.

II. PROVIDER DIRECTORY INFORMATION

Specify Tax Identification Number (T.I.N.) used for billing at each address. Indicate which offices are handicapped accessible.

**Principal Office Address**

(Street)____________________________________________________

(City, State, Zip)_______________________________________

(Telephone)_____________________________________________

TIN#___________________________
Handicapped Accessible [ ] Y [ ] N

**Second Office Address**

(Street)____________________________________________________

(City, State, Zip)_______________________________________

(Telephone)_____________________________________________

TIN#___________________________
Handicapped Accessible [ ] Y [ ] N

**Third Office Address**

(Street)____________________________________________________

(City, State, Zip)_______________________________________

(Telephone)_____________________________________________

TIN#___________________________
Handicapped Accessible [ ] Y [ ] N

**Residence**

(Street)____________________________________________________

(City, State, Zip)_______________________________________

(Telephone)_____________________________________________

TIN#___________________________
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<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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<tbody>
<tr>
<td><strong>Principal Office</strong></td>
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<tr>
<td><strong>Secondary Office</strong></td>
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- Do you make house call?    [ ] Yes [ ] No
- Do you speak a foreign language?    [ ] Yes [ ] No Specify language(s)______________________________
- Does any member of your staff speak a foreign language?
  [ ] Yes [ ] No Specify Language(s):______________________________
  If yes, specify at which office site:______________________________
- Is your office computerized?    [ ] Yes [ ] No
  If yes, type of software______________________________
- Does your office bill electronically?    [ ] Yes [ ] No

Please list below the names of any hospitals, facilities or health care organizations with which you have active association, employment, privileges, or practice. If additional space is required, please attach a separate sheet. Please specify type of privileges (attending, consulting, etc.)

**Facility Name**________________________________________________
**Dept.**________________________________________________
**Address**________________________________________________

**Date of Association**_________________________________________________________________________________
**Type of Privileges**_________________________________________________________________________________

**Facility Name**________________________________________________
**Dept.**________________________________________________
**Address**________________________________________________

**Date of Association**_________________________________________________________________________________
**Type of Privileges**_________________________________________________________________________________

Do you have any limitations of privileges at any of the above hospitals?    • Yes [ ] No [ ]

* If yes, attach full details.
Was your association, employment, privileges or practice at any institution, facility, or health care organization ever discontinued, restricted, suspended, voluntarily surrendered in lieu of pending adverse action or been made subject to supervision or probationary terms?  • Yes [ ] No [ ]

* If yes, attach full details.

(1) Name_______________________ Address_____________________
City_________________________ Telephone#__________________
(2) Name_______________________ Address_____________________ 
City_________________________ Telephone#__________________
(3) Name_______________________ Address_____________________ 
City_________________________ Telephone#__________________

Which of your covering Dentists will participate in Sele-Dent, Inc.?  [ ] 1 [ ] 2 [ ] 3

III. DENTAL LIABILITY

LIABILITY INFORMATION

Do you have professional liability coverage?  Yes [ ] No [ ]

Name of Carrier__________________________________________ Policy __________________________

Coverage Limits: _______________________ per Occurrence___________ Aggregate______________

Expiration Date: _____________________________

Have you changed your professional liability carrier within the past ten years?  * Yes [ ] No [ ]

* If yes, please list your previous carrier(s), period(s) of coverage and policy number(s) on a separate sheet.

Do you have any general liability coverage? [ ] Yes [ ] No

Name of Carrier__________________________________________ $_____________________________

Coverage Limits__________________________

Questions

• Are you presently involved in any malpractice suit(s)?  * Yes [ ] No [ ]

• Have you ever previously been involved in a malpractice suit?  * Yes [ ] No [ ]

• Has any payment been made by you, or on your behalf, as a result of a malpractice claim settlement not involving litigation, a settlement that occurred prior to a judgment involving litigation, or a settlement that was the result of a judgment involving litigation?  * Yes [ ] No [ ]

* If you answered yes to any of the above questions, please complete the following medical malpractice history form for each case in which you were involved within the past ten years which includes both new and resolved cases. If you answered yes to any of the above questions but have not been involved in any pending or settled claims within the past 10 years, so state.

The above information will be kept in strict confidence.
Please complete this section if you reported any malpractice actions on your application. If additional sheets are required, please photocopy this page prior to completion. A separate sheet should be used for each malpractice action.

Name of Patient____________________________________________________

Your relationship to patient:
[ ] Attending Dentist [ ] Attending Oral Surgeon [ ] Assistant Oral Surgeon [ ] Consultant [ ] Other

Location of Incident: ______________________________________ Date Reported:____________________

Insurance Carrier:____________________________________________________________

Additional Defendants:_____________________________________________________________________________

Status of Claim

Check appropriate box:
[ ] Open [ ] Closed
If closed, indicate method of closing: [ ] Dismissal [ ] Dropped [ ] Settled [ ] Judgment

Amount of Settlement or Judgment:__________________________________________________________

Date of Payment:______________________

Please describe the care you rendered and treatment prescribed for the patient.

Condition and diagnosis at time of incident:____________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Dates and description of treatment rendered:_______________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Condition of patient subsequent to treatment:_______________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

The above information will be kept in strict confidence.
- Has your license to practice dentistry in any state ever been revoked, restricted, suspended, voluntarily surrendered in lieu of pending adverse action, or been made subject to probationary terms, reprimand, censure, supervision or fine?  
  • Yes [ ] No []

- Has your license to dispense or prescribe any narcotic ever been denied, revoked, restricted, suspended, voluntarily surrendered in lieu of pending adverse action, or been made subject to probationary terms?  
  • Yes [ ] No []

- Have you ever been the subject of an investigation into possible wrongdoing by any administrative agency (Federal, State or Local) including but not limited to Medicare, Medicaid, or CUA program authorities?  
  • Yes [ ] No []

- Have you ever been placed on probation, fined, suspended, reprimanded or censured by and Federal, State or Local agency, including but not limited to Medicare, Medicaid or CUA program authorities?  
  • Yes [ ] No []

- To your knowledge, has information pertaining to you ever been reported the National Practitioner Databank?  
  • Yes [ ] No []

- Have you ever been convicted for violation of law other than a traffic offense or been the subject of a criminal incident?  
  • Yes [ ] No []

- Have you been the subject of any Civil suit concerning professional misconduct (other than malpractice, which is addressed previously)?  
  • Yes [ ] No []

- Do you have any physical or mental health condition, treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and requested specialty(ies) or which in any pose a risk of harm to your patients?  
  • Yes [ ] No []

- Have you ever been the subject of any complaints concerning inappropriate sexual conduct, harassment, or exploitation?  
  • Yes [ ] No []

- Has disciplinary action ever been taken against you by an ethics committee, licensing board, professional association or educational, training or healthcare institution organization?  
  • Yes [ ] No []

- Have you ever had your membership in any professional, organization or association revoked, suspended, denied, or not renewed by association choice?  
  • Yes [ ] No []

- Have you ever voluntarily relinquished membership in any professional, organization or association in lieu of pending adverse action?  
  • Yes [ ] No []

- Are you currently under investigation or have you ever been convicted, suspended or assessed a civil penalty under the anti-fraud and abuse provisions of the Medicare or Medicaid programs.  
  • Yes [ ] No []

- Have you ever had or do you have any limitations or admitting, surgical or other privileges in any hospital, institution, or healthcare facility other than those listed on the third page of this application.  
  • Yes [ ] No []
• Have you ever voluntarily relinquished membership in any professional, organization or association in lieu of pending adverse action?  
  • Yes [ ] No [ ]

• Are you currently under investigation or have you ever been convicted, suspended or assessed a civil penalty under the anti-fraud and abuse provisions of the Medicare or Medical programs?  
  • Yes [ ] No [ ]

• Have you ever had or do you have any limitations or admitting, surgical or other privileges in any hospital, institution, or healthcare facility other than those listed on the third page of this application?  
  • Yes [ ] No [ ]

• Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic center, hospital, surgi-center, or other business dealing with the provision of health services, equipment or supplies?  
  • Yes [ ] No [ ]

• If yes to any of the above, please provide details. Attach additional pages if necessary.
[ ] PROFESSIONAL CORP.      [ ] PARTNERSHIP      [ ] IPA      [ ] OTHER

Type of Practice: Solo__________  Single Specialty Group_________  Multi Specialty Group_________

Name of Practice_____________________________________

Practice, Specialty (ies):________________________________________

Tax Identification Number________________________________________

Billing Names:________________________________________

(As indicated on IRS W-9 Form)

Billing Address:________________________________________________________________________________

(As indicated on IRS W-9 Form)

City:______________________________________  State:________________

Zip________________

(As submitted on claim form)

Remittance should be sent to where services are rendered?     [ ] Yes     [ ] No

I hereby certify that all of the responses and information provided pursuant to the above questions and requests included in this application are complete, true and correct to the best of my knowledge and belief and fully understand that any significant misstatements in or omissions from this application constitute cause for dismissal of appointment or cause for summary dismissal from the Network. If any material changes occur in the information provided in this application affecting my professional status, I understand and agree that it is my obligation to notify Sele-Dent, Inc. within five (5) business days of such occurrence.

Signature:________________________________________

Date:__________________________

The following required information checklist is provided for your convenience.

(FAILURE TO INCLUDE ANY OF THE FOLLOWING DOCUMENTS MAY RESULT IN A DELAY OR INACTIVATION OF YOUR APPLICATION!!!)

- A current state license/registration-signed by the applicant.
- A current federal DEA registration.
- A current state specific DEA or CDS registration, as required by the State in which you practice.
- A current Dental malpractice face sheet which includes the applicant’s name, policy limits and limitations, the effective dates and the specialty(ies) of practice; if this is a group umbrella policy, please provide a document from the broker/carrier naming the applicant as insured.
- Hospital affiliation letters. You must still complete the application section even though you furnish these letters.
- Board Certification(s) (documentation with copies), if applicable.
- If your are Board Eligible, please submit proof of your Board Eligibility form the Boards, or proof of completion of an approved Residency/Fellowship training program.
- A curriculum vitae (CV) or resume which accounts for all training and work/practice history since graduation from your professional school with an explanation for all gaps between training periods and/or jobs.
- 2 fully signed and dated agreements – See page 7.
- A fully singed and dated application – See pages 7 and 8.
- Academic appointments, if applicable.
- Copy of professional school diploma(s).
Your TIN# (tax identification number)
Your Social Security number.

I hereby authorize SELE-DENT, INC. and/or its designates to consult with hospitals, institutions, or healthcare organizations with which I have been associated and with others who may have information bearing on my professional competence, character, ethical qualifications, pending malpractice suits, judgments or settlements of a malpractice action or any finding of professional misconduct. I hereby further consent to the inspection by SELE-DENT, INC. and/or its designees of all documents that in their opinion may be material to an evaluation of my professional qualifications and competence, for utilization and quality assurance purposes, and to evaluate my moral and ethical qualifications for membership.

I hereby release from liability all representatives of SELE-DENT, INC. and/or its designees for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to SELE-DENT, INC and/or its designees in good faith and without malice concerning my professional competence, ethics, character and other qualifications. I hereby consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of surgical-medical privileges and any other information which may be necessary to obtain in order to fulfill statutory and regulatory requirements to SELE-DENT, INC. and/or its designees or to hospitals where I may have applied for staff privileges.

I hereby further authorize SELE-DENT, INC. and/or its designees to communicate to hospitals, institutions and healthcare organizations with legitimate interest therein, any information concerning my professional competence, character, ethics and conduct, as well as any other information which must be disclosed in accordance with statutes and regulatory requirements that SELE-DENT, INC. and/or its designees may have to acquire, and, where such communication is made in good faith and without malice, I consent there to and agree to hold SELE-DENT, INC. and its authorized representatives and/or its designees free of liability therefore.

I hereby authorize my Dental Liability Insurance carrier to annually provide SELE-DENT, INC. and/or its designees with a copy of my Certificate of Insurance of Professional Liability Coverage (insurance holder) and updated claims experiences. In the event of any material change in, cancellation of, or failure to renew any professional liability coverage, I request and authorize SELE-DENT, INC. and/or its designees be given immediate written notice by any professional liability carrier. I hereby release my Dental Liability Company and its representative for the provision of such information to SELE-DENT, INC. and/or its designees.

A photocopy of this waiver shall be as effective as the original when so presented.

DATED: __________________________________________

NAME: __________________________________________
(Please Print Name)

SIGNATURE: __________________________________________
(No Signature Stamps Please)

PLEASE ENSURE THAT THIS APPLICATION IS SIGNED ON PAGES 7 & 8