PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is made this__day of_____, 2020 by and between SELE-DENT, INC., One Huntington Quadrangle Suite 1S03 Melville New York 11747 and

DENTIST NAME: _____

Address: _____

_____

WHEREAS, SELE-DENT, INC., has established a network of Dentists to render services to employees/members ("Eligible Participants") of certain employers, unions and organizations ("Clients");

WHEREAS, the Dentist wishes to become a member of such Network; and

WHEREAS, this Agreement shall set forth the terms and provision of the understanding of the parties.

NOW, THEREFORE, in consideration of the mutual covenants and provisions contained herein, the parties agree as follows:

SECTION ONE – Dentist Obligations

1.1 Dentist agrees to become a member of Sele-Dent's Network of Dentists. Dentist shall maintain at all times a valid, full and unrestricted license to practice dentistry. Dentist agrees to abide by Preferred Provider's (as such term is defined in Section 1.3, below) credentialing requirements. Dentist shall participate in continuing education not less than in accordance with generally accepted dental practice standards at the time and in accordance with applicable credentialing standards. Dentist shall maintain dental records in accordance with applicable state and federal laws, regulations, and requirements.

1.2 Dentist shall be solely responsible for the quality and appropriateness of services rendered to Eligible Participants. Dentist shall be responsible for verifying that an individual is an Eligible Participant who is covered for dental services and the number of visits to which the Eligible Participant is entitled. Verification may be attained through identification card, facsimile or telephone authorization.

1.3 Dentist agrees to accept any individual who is enrolled in a Health Plan and entitled to receive benefits for certain health care services under a Subscription Agreement with any organization or entity (a "Preferred Provider") which has contracted with Sele-Dent, Inc.

A Health Plan" shall mean any plan, group insurance policy, prepaid or fee for service agreement, contract, program or other similar arrangement entered into with a Payor (as defined below), including such plans or arrangements created or established under the auspices of a managed care "no-fault" automobile insurance program or a managed care workers' compensation program, which provides for the payment, reimbursement and/or furnishing of health services to Eligible Participants. A "Payor" shall mean those entities which have contracted with Sele-Dent, Inc. or with any Preferred Provider to provide reimbursement to Dentist as part of such Preferred Provider's fee schedule for covered services.

1.4 Dentist shall have the ultimate responsibility for services provided to Eligible Participants, including but not limited to, all dentist-patient responsibilities, referrals to specialists and/or health care providers. Dentist shall be solely responsible for all decisions regarding health care of Eligible Participants receiving care in his/her practice.

1.5 Dentist will render covered services to Eligible Participants in the same manner and with the same degree of quality, as he/she does for his/her private patients in a non-discriminatory manner.

1.6 Dentist hereby agrees that Dentist will not deny the provision of Covered Services to Eligible Participants by virtue of the Eligible Participant being covered by any agreement between Sele-Dent, Inc. and a Preferred Provider.

1.7 If a referral is necessary, either to a physician, dentist, clinical laboratory or diagnostic center, Dentist agrees to refer eligible participants to a Preferred Provider participant from a list provided by Sele-Dent, Inc. Prior approval from Preferred Provider is required for referral to non-participating physicians or other non-participating health care providers except in situations where there will be an immediate and substantial bodily injury to an Eligible Participant in the absence of intervention of a non-participating health care provider. Under such circumstances, Dentist agrees to notify the Preferred Provider and Sele-Dent, Inc. within 24 hours.

1.8 Dentist agrees to cooperate with Sele-Dent, Inc. and all Preferred Providers and their payors or payor's designees, concerning utilization review procedures, quality assurance programs, credentialing and recredentialing programs, policy guidelines and referral procedures.

1.9 Dentist agrees not to seek or accept additional compensation or reimbursement from any Eligible Participant for Covered Services except for:

(a) co-payment;
(b) deductibles;
(c) amounts due for non-covered services; and
(d) Co-insurance.

Dentist agrees to assure that payment is obtained from Worker's Compensation or no-fault auto insurance when such payments are available. Dentist further agrees to accept a Preferred Provider's maximum allowable fee schedule for State Workers' Compensation schedule for Dentist's applicable region, whichever is less, for those Eligible Participants who are enrolled in a Preferred Provider's managed care worker's compensation program or a managed "no-fault" program. Such Eligible Participants will be identifiable by a special designation on an Eligible Participant's ID card. Only if a Dentist is approved by the Preferred Provider will Dentist receive reimbursement for the performance of specialized procedures. Except as set forth above, if due to a payor's utilization review activity or a Preferred Provider's utilization review activity, there is a reduction or denial of benefits, Dentist agrees not to bill or otherwise attempt to collect those amounts from the Eligible Participant.

1.10 Dentist agrees to maintain specialty appropriate professional liability insurance policies of a minimum of $1 million per claim/$3 million for all claims in greater amounts if deemed necessary by Sele-Dent, Inc. Dentist further agrees to provide Sele-Dent, Inc. evidence that such policy is in force.

1.11 Dentist agrees to immediate verbal notification, followed by written notification within three (3) business days in the event of the following.

(a) Change of Dentist's office address or billing and/or telephone number; or
(b) Change of Dentist's tax ID number;
(c) Any action taken resulting in final decision to restrict, suspend or revoke license to practice dentistry or his/her dental staff privileges;
(d) Any action taken to censure, reprimand or fine Dentist or place Dentist on probation;
(e) Any lawsuit filed against the Dentist for malpractice and the final disposition of legal action;
(f) A lapse, cancellation or modification of Dentist's professional liability insurance as required by this Agreement; or
(g) Any other situation that might affect Dentist's ability to carry out his/her duties or obligations under this Agreement.

1.12 Dentist agrees to permit Sele-Dent, Inc., and a Preferred Provider to use his/her name, address, telephone number and description of services in the Directory of Participating Providers and any other materials necessary.

1.13 Dentist agrees to cooperate with Sele-Dent, Inc. and any Preferred Provider in resolving any grievances related to Dentist's Covered Services to Eligible Participants or administrative issues.

1.14 Should an Eligible Participant's benefit program require the payment of any deductibles, co-payments, or co-insurance amounts, Dentist shall collect and retain the amount payable by the covered person. The fee paid, along with the monies collected shall not exceed the amount shown in the fee schedule. Dentist may charge and collect for non-covered services when the covered person has requested such services and has been advised that such services are non-covered.

1.15 All claims for Covered Service rendered to Eligible Participants shall be submitted within fifty-five (55) days of the date of service. Claims submitted after eleven (11) months from the date of service will not be honored.

1.16 Dentist agrees to make all arrangements to ensure twenty-four (24) hour/three hundred sixty-five (365) days per year availability or coverage of healthcare services by a Sele-Dent, Inc. Provider to all Eligible Participants under his/her care.

1.17 Dentist must provide ninety-five (95) days prior written notice to Sele-Dent, Inc. if he or she elects not to accept additional covered Eligible Participants.

SECTION TWO – Sele-Dent, Inc. Obligations

2.1 Sele-Dent, Inc., agrees to market Dental services as a Preferred Provider in the Sele-Dent, Inc. Network to all its prospective clients.

2.2 Sele-Dent, Inc., will assure that its clients print a Directory of participating dentists which will be made available to their members/employees.

2.3 A copy of the Directory will be provided to each Dentist participating in the Network.

2.4 Sele-Dent, Inc. agrees to pay Dentist within 30 business days after Sele-Dent, Inc's. receipt of payment for a Covered Service from a Payor. Sele-Dent, Inc. will make a best effort to enforce such Agreement. However, Sele-Dent, Inc. is not responsible for payment of claims unless it has received reimbursement from a Payor for a Covered Service.

2.5 Fees for services covered under this Agreement will be paid by Sele-Dent, Inc. clients to the Dentist. Dentist agrees not to seek or accept payment from any Eligible Participant for Covered Services except as stated in Section 1.9 and 1.14 supra. The fee will be as per the agreed upon fee schedule, a sample of which is attached hereto as Exhibit I. Dentist agrees to accept this payment as payment in full for Covered Services rendered.

2.6 Claims for payment must be submitted by the Dentist to Sele-Dent, Inc. or when designated by Sele-Dent, Inc. directly to its clients, or universal insurance claim forms and must be complete, accurate and legible. Claims shall be completed using ADA coding.

SECTION THREE – Confidentiality

Subject to Federal and State laws, rules and regulations, Dentist agrees to permit Sele-Dent, Inc., and any Preferred Provider, access to Eligible Participants' dental records in connection with its utilization review, quality assurance programs, peer or grievance reviews and also agrees to follow Sele-Dent, Inc. or its representatives to inspect office sites when required. Further, each party agrees that all documents, all records pertaining to a patient's personal, dental and treatment history, and all communications relating to this Agreement shall be deemed confidential and that it will not disclose such documents, records, information and communications to anyone else. Notwithstanding the foregoing, at Eligible Participant's request or with Eligible Participant's permission, records may be transferred to consultants and related professionals involved in the Eligible Participants' care.

SECTION FOUR – Effective and Termination Dates

4.1 This Agreement shall become effective when signed by both parties. The initial term of this Agreement shall be for one year from the effective date. This Agreement will be automatically renewed at each anniversary date for an additional one (1) year term.

4.2 Should either party desire to terminate this Agreement at any time, without cause, written notice must be provided at least ninety (90) days prior to the effective date of such termination.

4.3 This Agreement may be terminated upon receipt by Sele-Dent, Inc. of written notification from any Preferred Provider or Payor stating that it has received evidence that the Dentist has falsified or failed to report any credentialing or malpractice information or Dentist's license to practice dentistry or dispense narcotics is revoked, restricted, suspended, voluntarily relinquished or made subject to probationary terms; limitation, reduction or loss of hospital privileges for a period longer than fifteen (15) days; lapse, loss or reduction of professional liability insurance below the $1 million/$3 million limits pursuant to this Agreement.

4.4 Each party may terminate this Agreement upon written notice in the event of a default in the performance of any of the other party's obligations under this Agreement which default is not satisfactorily cured within thirty (30) days of receipt of written notice of said default.

4.5 Either party may terminate this Agreement immediately upon written notice in the event the other party ceases doing business as a going concern, dissolves, has a receiver appointer, makes an assignment for the benefit of creditors or commences a proceeding under any bankruptcy or insolvency laws.

4.6 Following the effective date of termination, this Agreement shall be of no further force of effect, except that each party is liable for any obligations or liabilities arising from activities carried on by it hereunder to the effective date of termination of this Agreement.

4.7 In the event of termination of this Agreement, Dentist shall immediately notify any Eligible Participant seeking the professional services of Dentist after the date of such termination that Dentist is no longer a Dentist participating in the Sele-Dent, Inc. Network, and he/she will refer the Eligible Participant directly to Sele-Dent, Inc. for further disposition.

4.8 Notwithstanding other termination provisions of this Agreement, this Agreement may be unilaterally amended by Sele-Dent, Inc. upon thirty days written notice. If the Dentist determines that he/she wishes to leave the Network rather than accept the amendment to the Agreement, the Dentist is obligated to notify Sele-Dent, Inc. within the 30 day period and to cease seeing new patients at the close of the 30 day period. If Dentist is in the middle of treating a patient, Dentist may continue to see such patient at the current Sele-Dent, Inc. fee schedule until patient finds another Dentist or 60 days have elapsed, whichever is shorter.

SECTION FIVE – Miscellaneous

5.1 This Agreement is governed by the laws of the State in which the treatment is rendered. For those providers practicing in New York and New Jersey, the State in which treatment was rendered is the jurisdiction which is applicable.

5.2 Sele-Dent, Inc. and Dentist are independent legal entities and are performing the services hereunder as independent contractors and no joint venture, partnership, employment, agency or other relationship is created by this Agreement. Neither Dentist nor Sele-Dent, Inc. is authorized to represent the other for any purposes.

5.3 This Agreement may not be assigned by Dentist to any other person or practitioner without the express written approval of Sele-Dent, Inc.

5.4 Any notice required hereunder should be given in writing an sent by first class mail to the other party at the address set forth herein or such other address as may be designated. Such notice shall be effective upon receipt.

5.5 This Agreement, together with all Exhibits incorporated herein constitutes the entire Agreement between the parties hereto.

Please sigh and date this Agreement on page 7.

IN WITNESS WHEREOF this Agreement has been executed by the parties hereto on the dates set forth below.

Dentist

Date: _____ Signature: _____

Name: _____

Address: _____

_____

Phone Number:

_____

Tax ID Number: _____

SELE-DENT, INC.

Date: _____ By: _____

One Huntington Quadrangle Suite 1S03
Melville, New York 11747
1-800-520-3368

PRACTICE INFORMATION AND LETTER AGREEMENT FORM

COMPLETE, SIGN AND RETURN TO: One Huntington Quadrangle Suite 1S03 Melville, NY 11747

PERSONAL DATA

Last Name First Name License Number Tax I.D. Number for Insurance Billing

Address Suite No. City Date of Birth

State Zip County

Telephone
Office ( ) Emergency ( ) Fax ( )

Dental School Degree Year Graduated

[ ] General Practice [ ] Specialty _____
[ ] Board Eligible [ ] Board Certified Do you limit your practice to your specialty [ ] Yes [ ] No

Post Graduate Courses (Dates & Description)

Professional Organizations

List other dental panels which you are a member of

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 From/To**	**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_____

If Board Eligible, expected exam date(s)? _____

Please attach copies of Board Specialty Certificates.

_____	_____	_____
Primary State of Licensure	License No.	Expiration Date
_____	_____	_____
Secondary State of License	License No.	Expiration Date

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#_____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Principal Office						
Secondary Office						

- 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 Priviliges_____

Facility Name_____ Dept._____

Address_____

Date of Association_____

Type of Priviliges_____

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)	(2)	(3)
Name_____	Name_____	Name_____
Address_____	Address_____	Address_____
City_____	City_____	City_____
Telephone#_____	Telephone#_____	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. <u>If additional sheets are required, please photocopy this page prior to completion.</u> 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 your 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, In 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

PLEASE COMPLETE AND FAX BACK WITH ALL ATTACHMENTS TO 516-887-7896

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

6 City, state, and ZIP code

Requester's name and address (optional)

Sele-Dent , Inc
1 Huntington Quad, Suite 1S03
Melville, NY 11747

7 List account number(s) here (optional)

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. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. 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
2. 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 I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

ADA Dental Claim Form

SELE-DENT, INC.
One Huntington Quadrangle Suite 1S03
Melville, New York 11747
1-800-520-3368 Fax 1-516-887-7896

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) –

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) Date

54. Provider ID | 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) –

58. Treating Provider Specialty

SELE-DENT, INC
FEE SCHEDULE
2020

Proc Code	EXPLANATION OF CODE	Fee Amount	Proc Code	EXPLANATION OF CODE	Fee Amount
120	ORAL EXAM(PERIODIC)	15.00	2644	ONLAY PORC/CERAMIC 4 SURF	350.00
140	LIMITED ORAL EVALUATION	15.00	2710	CROWN ACRYLIC	225.00
150	COMP ORAL EVALUATION	15.00	2720	CROWN ACRYLIC W/GOL	225.00
160	EXTENSIVE ORAL Exam	28.00	2740	CROWN PORCELAIN	330.00
180	COMP PERIO EVAL	15.00	2750	CROWN PORCELAIN/ MET	330.00
210	XRYS INT COMP SERIES	25.00	2751	CROWN PORC/BASE MET	330.00
220	XRYS INT PER 1ST FILM	4.00	2752	CROWN PORC/NOBEL MET	330.00
230	XRYS INT PER ADD FILM	3.00	2790	CROWN GOLD(FULL)	275.00
240	XRYS INT OCCLUSAL	9.00	2799	PROVISIONAL CROWN	200.00
250	XRYS-EXTRA ORAL	18.00	2910	RECEMENT INLAY	15.00
260	XRYS EXTRA ORAL ADD	18.00	2915	RECEMENT POST	15.00
270	XRYS BITEWING EACH	5.00	2920	RECEMENT CROWN	15.00
272	XRYS 2 BITEWINGS	9.00	2930	CROWN-STNLESS	60.00
274	XRYS 4 BITEWINGS	17.00	2932	PREFABRICATED RESIN CROWN	38.00
320	XRYS TEMPORO-MAND	25.00	2940	SEDATIVE FILLING	15.00
322	TOMOGRAPHIC SURVEY	375.00	2950	CORE BUILD UP INCLUDING ANY PINS	28.00
330	XRYS PANORAMIC FILM	39.00	2952	CRN-CAST POST/CORE	80.00
340	XRYS-CEPHAL FILM	25.00	2954	PREFABRICATED POST & CORE	80.00
364	CONE BEAM CT CAPTURE	75.00	2955	POST REMOVAL	125.00
365	CONE BEAM CT CAP MANDIBLE	75.00	2960	LAMINATE- VENEER CHAIRSIDE	175.00
366	CONE BEAM CT CAP MAXILLA	75.00	2999	CROWN-TEMP-CRACKED	30.00
367	CONE BEAM CT CAP MAN/MAX	75.00	3110	PULP CAP DIRECT	12.50
368	CONE BEAM CT CAP TMJ SERIES	75.00	3120	PULP CAP INDIRECT	11.00
431	ADJUNCTIVE PRE-DIAG TEST	50.00	3220	PULPOTOMY-THERAP	22.00
460	PULP VITALITY TEST	10.00	3221	VITAL PULPOTOMY-	30.00
470	DIAGNOSTIC STUDY	20.00	3310	ROOT CANAL 1 CANAL	135.00
490	MISC TEST/LAB	15.00	3320	ROOT CANAL 2 CANALS	220.00
1110	PROPHYLAXIS – ADULT	25.00	3330	ROOT CANAL 3 CANALS	300.00
1120	PROPHYLAXIS – CHILD	20.00	3331	ROOT CANAL OBSTRUCTION	175.00
1206	FLUORIDE TOPICAL VARNISH	12.00	3346	RETREAT 1 CANAL	135.00
1208	FLUORIDE TOPICAL W/O VARNISH	12.00	3347	RETREAT 2 CANALS	220.00
1310	DIET PLANNING	12.00	3348	RETREAT 3 CANALS	300.00
1330	DENTAL HYGIENE INSTR	10.00	3351	RECALCIFICATION	12.50
1351	TOP APPL OF SEALANTS	12.00	3410	APICOECTOMY ANTERIOR	70.00
1510	SPACE MAINT FIXED UNI	75.00	3421	APICOECTOMY PREMOLAR	105.00
1516	FIXED SPACE MAINT MAXILLARY	100.00	3425	APICOECTOMY MOLOR	200.00
1517	FIXED SPACE MAINT MANDIBULAR	100.00	3426	APICOECTOMY / ADD ROOT	36.00
1520	SPACE MAINT-REMOVABLE UNILATERAL	100.00	3430	RETROGRADE FILLING	50.00
1526	SPACE MAINT- REMOVABLE MAXILLARY	95.00	3440	APICAL CURETTAGE	80.00
1527	SPACE MAINT- REMOVABLE MANDIBULAR	95.00	3450	ROOT AMPUTATION	85.00
1550	RECEMENT SPACE MAINTAINER	20.00	3910	ISOLAT OF TTH W/RUBBER DAM	200.00
1555	REMOVAL OF FIXED SPACE MAINT	30.00	3920	ENDO-HEMISECTION	110.00
2140	AMALGAM 1 SURFACE	16.50	3950	CANAL PREP FOR POST	60.00
2150	AMALGAM 2 SURFACE	28.00	4210	GING PER QUADRANT	155.00
2160	AMALGAM 3 SURFACE	38.00	4211	GING PER SECTANT	80.00
2161	AMALGAM 4 SURFACE	40.00	4212	GINGIVECTOMY PER TOOTH	20.00
2330	RESIN-BASED COMP/1SUF	28.00	4231	ANATOMICAL CRN EXPOSURE	330.00
2331	RESIN-BASED COMP/2SUF	44.00	4240	GINGIVAL FLAP PROCEDURE	100.00
2332	RESIN-BASED COMP/3SUF	80.00	4241	GINGIVAL FLAP CURETTAGE	50.00
2335	RESIN-BASED COMP/4SUF	80.00	4249	CROWN LENGTHENING	80.00
2391	RES BAS COMP 1 SURF POST	38.00	4260	OSSEOUS SURGERY QUAD	325.00
2392	RES BAS COMP 2 SURF POST	54.00	4261	OSS SURG 1 TO 3 PER QUAD	162.50
2393	RES BAS COMP 3 SURF POST	90.00	4263	BONE REPLACE GRAFT FIRST QUAD	150.00
2394	RBC COMP 4 SURF OR MORE	100.00	4264	BONE REPLACE GRAFT EACH ADD	150.00
2510	INLAY-METALLIC 1 SURF	135.00	4265	OSSEOUS TISSUE REGENERAT	60.00
2520	INLAY-METALLIC 2 SURF	160.00	4266	GUIDED TISSUE REGION	75.00
2530	INLAY-METALLIC 3 SURF	200.00	4267	GUIDED TISSUE REG./ NON	150.00
2544	ONLAY METALLIC PER	150.00	4268	SURGICAL REVISION, PER TTH	375.00
2610	INLAY-PORCELAIN 1SURF	80.00	4270	PEDICLE SOFT TISSUE GRAFT	80.00
2620	INLAY-PORC/CERAMIC 1 SURF	80.00	4273	AUTO CONNECT TISSUE GRAFT	100.00
2630	INLAY PORC/CERAMIC 2 SURF	350.00	4320	PROV SPLINTING INTRACORONAL	55.00
2642	ONLAY PORC/CERAMIC 2 SURF	350.00	4321	PROV SPLINTING EX	80.00
2643	ONLAY-PORC/CERAMIC 3 SURF	350.00	4341	PERIO SCALING	22.50

SELE-DENT, INC
FEE SCHEDULE
2020

Proc Code	EXPLANATION OF CODE	Fee Amount	Proc Code	EXPLANATION OF CODE	Fee Amount
4342	PERIO SCAL ROOT PLAN 1-3 TTH	11.25	6241	PONTIC-PORCELAIN/BASE METAL	265.00
4346	PERIO SCALING FULL MOUTH	90.00	6245	PONTIC PORCELAIN/CERAMIC	265.00
4355	FULL MOUTH DEBRIDEMENT	60.00	6250	PONTIC-RESIN/HIGH NOBLE METAL	265.00
4381	ACTISITE	40.00	6251	PONTIC-RESIN/BASE METAL	265.00
4910	PERIO PROPHYLAXIS	40.00	6252	PONTIC- RESIN/NOBLE METAL	265.00
4921	GINGIVAL IRRIGATION	25.00	6710	RETAINER CROWN RESIN BASED COMP	135.00
5110	DENTURES-COMP UPPER	385.00	6720	RETAINER CROWN HIGH NOBLE METAL	265.00
5120	DENTURES COMP LOWER	385.00	6722	RETAINER CROWN HIGH NOBLE METAL	175.00
5130	DENTURES IMM UPPER	410.00	6740	RETAINER CROWN PORCELAIN/CERAMIC	330.00
5140	DENTURES IMM LOWER	410.00	6750	RETAINER CROWN PORCELAIN/H NOBLE METAL	330.00
5211	PRTL DENT UPP 2 CLSP	360.00	6751	RETAINER CROWN PORCELAIN BASE METAL	330.00
5212	PRTL DENT LOW 2 CLSP	360.00	6752	RETAINER CROWN NOBLE METAL	330.00
5213	PRTL DEN CAST 2 CLSP	375.00	6780	RETAINER CROWN 3/4 HIGH NOBLE METAL	200.00
5214	PRTL DEN CAST 2 CLSP	375.00	6790	RETIANER CROWN FULL HIGH NOBLE METAL	275.00
5221	IMMEDIATE MAX PART DENTURE RESIN	375.00	6792	RETAINER CROWN FULLNOBLE METAL	275.00
5222	IMMEDIATE MAN PART DENTURE RESIN	375.00	6793	PROVISIONAL RETAINER CROWN	135.00
5223	IMMEDIATE MAX PART DENTURE METAL	375.00	6930	RECEMENT BRIDGE	25.00
5224	IMMEDIATE MAN PART DENTURE METAL	375.00	6940	STRESS BREAKER	38.00
5225	PART UPP DENT-FLEX BASE	375.00	6950	PRECISION ATTACH	55.00
5226	PART LOW DENT-FLEX BASE	375.00	6985	PEDIATRIC PARTIAL DENT FIXED	55.00
5282	PRTL DENT UNI REMOV MAXILLARY	165.00	7111	DECIDUOUS TOOTH EXTRACTION	35.00
5283	PRTL DENT UNI REMOV MANDIBULAR	165.00	7140	ERUPT TTH EXPOSED ROOT EXT	65.00
5410	ADJ.COMPL.DENT UPPER	65.00	7210	EXTRACT ERUOTED TTH	100.00
5411	ADJ.COMPL. DENT LOWER	38.00	7220	EXTRACT IMPACT TTH	110.00
5421	PRTL DENT UPPER	38.00	7230	EXTRACT IMPACT PART	160.00
5422	PRTL DENT LOWER	28.00	7240	EXTRACT IMPACT FULL	245.00
5511	REPAIR BROKEN COMPLETE DENT MAN	60.00	7250	TOOTH RECOVERY	65.00
5512	REPAIR BROKEN COMPLETE DENT MAX	60.00	7260	ORAL ANT FISTULA	155.00
5520	REPL MISSING/BROKEN TTH	28.00	7261	MAX SINUSOTOMY	155.00
5611	REPAIR RESIN PARTIAL MAN	35.00	7270	TOOTH REIMPLANT	155.00
5612	REPAIR RESIN PARTIAL MAX	35.00	7272	TTH TRANSPLANTATION	200.00
5621	REPAIR CAST PARTIAL FRAME MAN	35.00	7280	EXPOSE IMPACT UNC0PL	55.00
5622	REPAIR CAST PARTIAL FRAME MAX	35.00	7282	MOBILIZATION MALPOSITION TTH	135.00
5630	PRTL DENT ADD TTH	18.00	7283	DEVICE FACILITATE ERRUPT IMP	200.00
5640	REPLACE BROKEN TEETH -PER TOOTH	28.00	7285	BIOPSY HARD TISSUE	55.00
5650	ADD TOOTH TO EXISTING PARTIAL DENT	44.00	7286	BIOPSY SOFT TISSUE	35.00
5660	PRTL DENTADD'L CLASP	62.00	7287	CYTOLOGY	55.00
5670	REP ALL TEETH (MAX)	36.00	7290	SURGICAL REPOSITION	85.00
5671	REP ALL TEETH (MANDI)	44.00	7310	ALVEOL W/EXTRACT	90.00
5710	DENT COMP UP REBASE	200.00	7311	ALVEOL UPPER JAW W/EXT	90.00
5711	DENT COMP LOWER REBASE	200.00	7320	ALVEOL NON EXTRACT	135.00
5720	DENT PART UPPER REBASE	165.00	7340	VESTIBIOPLASTY	60.00
5721	DENT PART LOWER REBASE	165.00	7350	PER ARCH COMPL	82.00
5730	RELINING COMPL UPPER	85.00	7410	RADICAL EXCISION <5"	60.00
5731	RELINING COMPL LOWER	85.00	7411	EXC BENIGN LESION > 1.25 CM	60.00
5740	DENT RELINE COMP UPPER	62.00	7412	EXC BENIGN LESION COMP	82.00
5741	DENT RELINE COMP LOWER	62.00	7413	EXC MALIG LES UP TO 1.25 CM	82.00
5750	RELINING COMP UPPER LAB	90.00	7450	ODO CYST <5"	125.00
5751	RELINING COMP LOWER LAB	90.00	7451	ODO CYST >5"	180.00
5760	DENT RELINE PRTL UPPER	77.00	7472	REMOVAL OF TORUS PALATINUS	82.00
5761	DENT RELINE PRTL LOWER	77.00	7473	REMOVAL TORUS MANDIBULARIS	110.00
5810	TEMP COMP UPPER DENT	85.00	7485	SURG REDUCTION OF OSSEOUS	190.00
5811	TEMP COMP LOWER DENT	85.00	7490	RADICAL RESECT MAND	1265.00
5820	TEMP PART UPPER DENT	55.00	7510	RAD INCIS INTRA ORAL	65.00
5821	TEMP PART LOWER DENT	55.00	7530	REMOVE FOREIGN BODY	60.00
5850	TISSUE CONDITIONING UPPER	25.00	7610	FRAC SIM MAXILLA OP	360.00
5851	TISSUE CONDITIONING LOWER	25.00	7620	FRAC SIM MAXILLA CL	250.00
5862	PRECISION ATTACHMENT	75.00	7630	FRAC SIMP MAND OPEN	375.00
6210	PONTIC- CAST HIGH NOBLE METAL	200.00	7640	FRAC SIMP MAN CLOSED	440.00
6212	PONTIC- CAST NOBLE METAL	120.00	7650	MALAR/ZYG ARCH OPEN	440.00
6240	PONTIC- PORCELAIN/HIGH NOBLE METAL	265.00	7660	MALAR/ZYG ARCH CLOS	165.00

SELE-DENT, INC
FEE SCHEDULE
2020

Proc Code	EXPLANATION OF CODE	Fee Amount			
7670	ALVEOLUS, RED SPLINT	110.00			
7671	ALVEOLUS - OPEN REDUCTION	110.00		**ORTHODONTICS SERVICES**	
7710	MAXILLA, OPEN	550.00		**LIFETIME MAXIMUM OF $ 4,400**	
7720	MAXILLA, CLOSED	250.00		*** AS LONG AS MEMBERSHIP ACTIVE**	
7730	MANDIBLE, OPEN	575.00			
7750	MALAR/ZYG ARCH OPEN	440.00			
7760	MALAR/ZYG ARCH CLOS	190.00			
7770	ALVEOLUS, RED SPLINT	110.00			
7771	FX ALEVEOLUS CLOSED REDUCT	110.00			
7810	OPEN REDUC OF DISLOC	440.00			
7820	CLOS REDUC OF DISLOC	105.00			
7830	MANIPU UNDER ANESTH	65.00			
7880	OCCLUS ORTHIC APPLIAN	100.00			
7910	SUTURE WOUND <2”	55.00			
7943	OSTEOTOMY-BONY GRAFT	450.00			
7950	OSTEOPERIOSTEAL by report	400.00			
7951	SINUS AUGMENTATION	400.00			
7953	BONE REPLACEMENT GRAFT	225.00			
7955	REPAIR MAXILLOFACIAL SOFT/HARD	400.00			
7960	FRENECTOMY	60.00			
7972	SURGICAL REDUCTION OF FIBROUS	60.00			
9110	PALLIATIVE TRTMENT	18.00			
9210	LOCAL ANESTHESIA	15.00			
9211	REGIONAL BLOCK ANESTHESIA	28.00			
9212	TRIGEMINAL DIV BLOCK ANES	38.00			
9215	LOCAL ANEST W/OPER OR SURG	75.00			
9222	GENERAL ANESTHESIA FIRST 15MINS	75.00			
9223	GENERAL ANESTHESIA + ADD 15MINS	75.00			
9230	ANALGESIA	75.00			
9239	IV- SEDATION/ANALGESIA 15MINS	75.00			
9243	IV- MODERATE SEDATION 15MINS	75.00			
9248	NON-IV CONSCIOUS SEDATION 15MINS	75.00			
9310	CONSULTATION	75.00			
9450	CASE PRESENT DETAIL/EXTEN	75.00			
9610	THERAPEUTIC DRUG INJ	40.00			
9612	THERAP PARENTERAL DRUG	40.00			
9911	DESENSITIZING RESIN PER TTH	32.00			
9944	OCCLUSAL GUARD HARD APPLIANCE	150.00			
9945	OCCLUSAL GUARD SOFT APPLIANCE	150.00			
9951	OCCLUSAL ADJUST	60.00			
9952	OCCLUSAL ADJUST COM	135.00			