



Application Checklist for Maryland Medical Assistance Program Application INDIVIDUAL DENTAL PROVIDER

If you are applying to enroll as an individual provider, please include the items in the following checklist with your enrollment packet.
Should you have any questions, please contact Scion Dental at Credentialing@sciondental.com (855) 812-9211

A completed application will include the following:

- Completed and signed Individual Provider Application. Please mark all blank fields "N/A".
- A copy of your NPI printout from NPPES
- If you provide services in a state other than Maryland, please include a copy of your board issued license from the state in which you are practicing.
- Include a copy of any certifications that indicate any specialties
- Completed and signed Disclosure of Ownership and Control
- Completed and signed Provider Agreement
- Completed Electronic Funds Transfer (EFT) form if you wish to receive payments via direct deposit. NOTE: this form is to be submitted only to the Comptroller of Maryland at the address indicated at the top of the form. Any EFT forms that are submitted directly to DHMH will not be processed.
- Any additional material including application addenda that may be required by specific programs.



Instructions for Maryland Medical Assistance Program Application INDIVIDUAL DENTAL PROVIDER

INSTRUCTIONS FOR COMPLETING MARYLAND MEDICAID ENROLLMENT FORMS FOR INDIVIDUAL PROVIDERS

Should you have any questions, please contact Scion Dental at Credentialing@sciondental.com (855) 812-9211

GENERAL INSTRUCTIONS	
1. Complete ALL items on the form unless otherwise instructed below. Failure to complete all required fields will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid. 2. Completion of signature fields is required. Initials or stamped signatures will not be accepted. 3. Please attach a copy of all requested documents. 4. These instructions do not need to be submitted with the application.	
MAIL TO	Unless instructed otherwise please mail completed enrollment applications and documentation to: Maryland Healthy Smiles: Credentialing P.O. Box 2059 Milwaukee, WI 53201

TYPE OF REQUEST	
NEW ENROLLMENT	The provider attempting to enroll in Maryland Medicaid has never been enrolled with Maryland Medicaid as a Fee for Service Provider.
RE-ENROLLMENT	The provider has previously been enrolled with Maryland Medicaid as a Fee for Service Provider, but the provider has been suspended or terminated from Maryland Medicaid.
RE-VALIDATION	The provider is actively enrolled in Maryland Medicaid Fee for Service, but, due to required law, is verifying their information with Medicaid on or before their five year Maryland Medicaid enrollment anniversary date.
INFORMATION UPDATE	The provider is actively enrolled in Maryland Medicaid and would like to change the information that is currently on file with Maryland Medicaid for the provider.
REQUESTED ENROLLMENT BEGIN DATE	If the provider has started rendering services, please indicate a Requested Enrollment Begin Date.
APPLICATION SUBMITTED DATE	Date filling out the application.

PROVIDER INFORMATION	
NATIONAL PROVIDER IDENTIFIER (NPI)	Enter the unique 10-digit NPI (Entity Type 1 Individual) of the provider who will be rendering services to Maryland Medicaid recipients. To obtain a NPI, please visit the following website: https://nppes.cms.hhs.gov/NPPES/Welcome.do . Please attach a printout from the previous website that lists the NPI information. If you are an Atypical provider and are not eligible to obtain a NPI, leave this field blank and Maryland Medicaid will assign a NPI to you.
MARYLAND MEDICAL ASSISTANCE PROVIDER NUMBER	This is a unique provider number generated by Maryland Medicaid for each provider. If you are a new enrollee, please leave this field blank. If you are an existing Maryland Medicaid provider, please fill in your 9-digit Maryland Medicaid Number.
PROVIDER TYPE	Enter the two-digit code for the appropriate provider type from the listing provided at the end of these instructions.
COUNTY CODE	Enter the two-digit code for the appropriate county code from the listing provided at the end of these instructions.
MEDICARE PROVIDER NUMBER	If you participate in Medicare, please list the provider number that has been assigned to you.
PROVIDER NAME	Individual practitioners should enter last, name, first name and middle initial.
DATE OF BIRTH	Enter the date of birth of the provider.
SOCIAL SECURITY NUMBER (SSN)	Enter the SSN of the individual to whom the Medicaid reimbursements will be made.
TELEPHONE NUMBER	Enter the best number to reach the provider or contact person who can speak on behalf of the provider regarding Maryland Medicaid participation.
E-MAIL ADDRESS	Enter the e-mail address of the provider or contact person who can speak on behalf of the provider regarding Maryland Medicaid participation.



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CORRESPONDENCE INFORMATION	
CONTACT INFORMATION	If the application is being filled out on behalf of the provider, enter the Name, Position/Title, Telephone and E-Mail address of the contact person who can speak on behalf of the provider regarding Maryland Medicaid participation.
PRACTICE ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the primary address in which the individual provider will be rendering services.
PRACTICE ADDRESS #2	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the secondary address in which the individual provider will be rendering services.
PRACTICE ADDRESS #3	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of any additional addresses in which the individual provider will be rendering services.
CORRESPONDENCE ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the address where any letters or correspondence should be sent. This address must be kept up to date. Requests to Re-Validate or Update Information are NOT issued electronically and will be sent to this address.
PAY TO ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the address where any paper checks and paper remittance advices should be sent.
ELECTRONIC CORRESPONDENCE	If you prefer to receive electronic correspondence and Remittance Advice, through an established eMedicaid account, check Yes.

LICENSE/PERMIT INFORMATION	
If applicable attach a copy of each license or certificate that is listed.	
PROFESSIONAL	Enter your professional license number, the State that issued the license, beginning effective date, and expiration date for each practice location in which you service Maryland Medicaid participants.
CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) NUMBER*	Enter your CLIA ID Number, beginning effective date, and expiration date.
DRUG ENFORCEMENT ADMINISTRATION (DEA)	Enter your Drug Enforcement Administration number if applicable.
MARYLAND LABORATORY PERMIT (MDLAB) OR LETTER OF PERMIT EXCEPTION NUMBER*	Enter your Office of Health Care Quality (OHCQ) issued MDLAB Number, beginning effective date, and expiration date. OR enter your OHCQ issued Letter of Permit Exception Number, beginning effective date, and expiration date.
NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAM (NCPDP)	Enter your NCPDP number if applicable.
PHARMACY	Enter your state issued license number if applicable.
ANESTHESIA LICENSE	Enter your state issued license number if applicable.
* Medical laboratory providers: Practitioners and other providers that perform medical laboratory services MUST COMPLETE and SUPPLY a copy of CLIA and MDLAB Permit/Letter of Permit Exception. Out-of-state providers that do not receive specimens originating in Maryland do not have to supply Maryland certification information but do have to state that they do not receive specimens originating in Maryland. Practitioners providing laboratory services to OTHER THAN THEIR OWN PATIENTS MUST enroll as medical laboratory providers.	

ADDITIONAL INFORMATION	
SPECIALTY INFORMATION	Physicians MUST enter the appropriate three-digit code from the specialty code listing provided at the end of these instructions. Please specify if you have another specialty not listed. Enter the primary specialty, specialty code (if physician), the date you were certified for your specialty in MMDDYY format, and the number, up to six digits, that was provided to you when you were certified for the associated specialty. Attach additional pages if more space is needed.
SPECIALTY VERIFICATION	Check the applicable statement and attach the required documentation.
LABORATORY INFORMATION	Answer the three questions listed in this section.
GROUP AFFILIATION	If you are a member of a group practice, please enter the name, organizational NPI, Maryland Medicaid number, and the effective date you became a member of the group. All rendering practitioners of a group must individually be enrolled as a Maryland Medicaid provider.
AUTHORIZATION	Please sign and date the application. No one can sign on the applicant's behalf.



Instructions for Maryland Medical Assistance Program Application INDIVIDUAL DENTAL PROVIDER

DISCLOSURE OF OWNERSHIP AND CONTROL	Maryland Medicaid is required to obtain disclosures on ownership and control from disclosing entities, fiscal agents, and managed care entities. Please fill out the six (6) sections and sign and date the Disclosure of Ownership and Control addendum. Failure to complete all required sections will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid. If a section is not applicable, please indicate this by checking the box at the end of each section and including the provider's signature.
PROVIDER AGREEMENT	Failure to complete the provider agreement will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid.
ELECTRONIC FUND TRANSFER (EFT)	If you wish to receive EFT, please complete this form and return to the address listed on this form, separately from the provider application.
PROVIDER ADDENDUM	If applicable to your provider type, please complete the attached addendum.

COUNTY CODE					
ALLEGANY	01	DORCHESTER	09	SOMERSET	19
ANNE ARUNDEL	02	FREDERICK	10	ST. MARY'S	18
BALTIMORE CITY	30	GARRETT	11	TALBOT	20
BALTIMORE COUNTY	03	HARFORD	12	WASHINGTON	21
CALVERT	04	HOWARD	13	WASHINGTON, DC	40
CAROLINE	05	KENT	14	WICOMICO	22
CARROLL	06	MONTGOMERY	15	WORCESTER	23
CECIL	07	PRINCE GEORGE'S	16	OTHER STATE	99
CHARLES	08	QUEEN ANNE'S	17		



Application for Participation in Maryland Medical Assistance Program INDIVIDUAL DENTAL PROVIDER

<p style="text-align: center;">IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION</p>	<p style="text-align: center;"><u>Unless Instructed Otherwise, Mail to:</u> Maryland Healthy Smiles: Credentialing P.O. Box 2059 Milwaukee, WI 53201</p>
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TYPE OF REQUEST			
Please select one.			
<input type="checkbox"/> NEW ENROLLMENT (Applicant has never enrolled with Maryland Medical Assistance)	<input type="checkbox"/> RE-ENROLLMENT (Provider is currently excluded/terminated from the Maryland Medicaid Program)	<input type="checkbox"/> RE-VALIDATION (Provider is enrolled and required to revalidate)	<input type="checkbox"/> INFORMATION UPDATE (Provider is enrolled and updating information to the provider's file)
Requested Enrollment Begin Date		Application Submitted Date	

PROVIDER INFORMATION		
NPI (Individual)	Maryland Medical Assistance Provider Number (If existing provider)	
Provider Type (Refer to instructions for appropriate codes.)	County Code (Refer to instructions for appropriate codes.)	
Medicare Provider Number		
Provider Last Name	First Name	MI
Date of Birth (MM/DD/YYYY)	Social Security Number (SSN)	
Telephone Number + extension	E-Mail Address	

CONTACT INFORMATION	
The contact name and email relate to the person who can answer questions about the information provided in this packet.	
Contact Name	Position/Title
Telephone	E-Mail Address

PRACTICE ADDRESS		
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number	



Application for Participation in Maryland Medical Assistance Program INDIVIDUAL DENTAL PROVIDER

PRACTICE ADDRESS # 2

Please enter other locations where you provide healthcare services for Maryland Medicaid recipients. Include all group addresses you are currently practicing under, if applicable. If additional space is needed, please attach additional pages.

Street Address		Suite/Department/Floor	
City	State	Zip Code (9 Digit)	
Telephone Number + extension		Fax Number	

PRACTICE ADDRESS # 3

Street Address		Suite/Department/Floor	
City	State	Zip Code (9 Digit)	
Telephone Number + extension		Fax Number	

CORRESPONDENCE ADDRESS

Please indicate where letters and claims forms, if any, should be sent.

Street Address		Suite/Department/Floor	
City	State	Zip Code (9 Digit)	
Telephone Number + extension		Fax Number	

PAY TO ADDRESS

Please indicate where checks & remittance statements should be sent.

Street Address		Suite/Department/Floor	
City	State	Zip Code (9 Digit)	
Telephone Number + extension		Fax Number	

ELECTRONIC CORRESPONDENCE

Would you prefer to receive electronic correspondence in lieu of paper when available?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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Application for Participation in Maryland Medical Assistance Program INDIVIDUAL DENTAL PROVIDER

LICENSE/PERMIT INFORMATION				
A copy of the license or certificate from the appropriate board or authority must be included as an attachment to this application. If more space is needed, please attach additional pages.				
Professional	State Issued	License Number	Date Issued	Expiration Date
CLIA	State Issued	License Number	Date Issued	Expiration Date
DEA	State Issued	License Number	Date Issued	Expiration Date
MDLAB	State Issued	License Number	Date Issued	Expiration Date
NCPDP	State Issued	License Number	Date Issued	Expiration Date
Pharmacy	State Issued	License Number	Date Issued	Expiration Date
Anesthesia	State Issued	License Number	Date Issued	Expiration Date

SPECIALTY INFORMATION	
If more space is needed, please attach additional pages.	
Primary Specialty	Specialty Code
Certification Date	Certification Number
Secondary Specialty	Specialty Code
Certification Date	Certification Number
Secondary Specialty	Specialty Code
Certification Date	Certification Number
Secondary Specialty	Specialty Code
Certification Date	Certification Number



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SPECIALTY VERIFICATION

(Please check the applicable statement and attach the required documentation. Pursuant to the Physicians Services Regulations (COMAR 10.09.02), THE Medical Assistance Program defines a Consultant-Specialist as a licensed physician who meets one of the criteria.)

- I have been declared board certified by a member of the American Board of Medical Specialists and currently retain that status. A photocopy of my specialty board certificate is attached.
- I have satisfactorily completed a residency program accredited by the Liaison Committee for Graduate Medical Education or by the appropriate residency review committee of the American Medical Association. Attached is a letter of verification from the chairman of the department where I completed my residency or where I am now working. This letter includes the name of the hospital where I completed my residency, length of my residency, by whom the program is accredited and the completion date of my residency.
- I have been declared board certified by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association. A photocopy of my specialty board certificate is attached.
- I have been declared board eligible by a specialty board approved by the Advisory Board of Osteopathic Specialists. Verification from my specialty board that I am board eligible is attached.
- I have completed a residency program in a foreign country. My qualifications and training are acceptable for admission in the examination system of the appropriate American Specialty Board. A letter of my specialty board verifying this is attached.

LABORATORY INFORMATION

Reimbursement for medical laboratory services you provide to eligible recipients are dependent on answering the following questions and supplying copies of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Permit Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.

Do you provide medical laboratory services for your own patients?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you provide medical laboratory services for other than your own patients?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you receive specimens that are obtained from other sites located in Maryland?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

All Maryland laboratories are required to have a Maryland Laboratory Permit or Letter of Permit Exception Number (§Health General Article §17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.



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GROUP AFFILIATION INFORMATION			
If additional space is needed, please attach additional pages.			
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date

AUTHORIZATION	
<p>I, the practitioner, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that if I or my group is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my group is salaried.</p>	
<p>_____</p> <p>Provider Signature (No stamps)</p>	<p>_____</p> <p>Date</p>
<p>_____</p> <p>Provider Name (Type or Print)</p>	<p>_____</p> <p>Date</p>



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DISCLOSURE OF OWNERSHIP AND CONTROL

Completion is required by 42 CFR Part 455.104. Failure to provide the information requested will cause the application to be returned. Attach additional pages as needed.

SECTION 1:

Disclosing Entity/Applicant (Individual named on page 1 of this application)

Name		NPI (Individual)	
Home Address – Street	City & State	Zip Code (9 Digits)	
Social Security Number (SSN)		Date of Birth (MM/DD/YYYY)	

Ownership in Applicant (Has direct or indirect ownership interest¹ of 5% or more. Include familial relationship to the Applicant and other Owners (spouse, parent, child, sibling), if any. The address for corporate entities must include every business address. See 42 CFR Part 455.104 (b)(1)(i) for more information.

Name of Individual or Entity	% of Ownership	NPI	
Address (Home Address if individual)	City & State	Zip Code (9 Digits)	
SSN (if individual)		Federal Employer Identification Number (if entity)	
Date of Birth (MM/DD/YYYY)		Familial Relationship (if individual, if any)	
Signature Required if Not Applicable			
<input type="checkbox"/> NOT APPLICABLE			

¹ A) “Ownership interest” means the possession of equity in the capital of, stock in, or of any interest in the profits of the disclosing entity.

B) “Indirect ownership interest” means any ownership interest in an entity that has ownership interest in the disclosing entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

C) “Determination of ownership or control percentage”

1) Indirect ownership interest – the amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A’s interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B’s interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

2) Person with an ownership or control interest – in order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of the disclosing entity’s assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider’s assets, A’s interest in the provider’s assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider’s assets, B’s interest in the provider’s assets equates to 4 percent and need not be reported.



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SECTION 2:

Agents and Managing Employees (e.g. office manager, administrator, director or other individuals who exercise operational or managerial control over the day to day operations of the provider. Include familial relationship to the Applicant (spouse, parent, child, sibling), if any. If additional space is needed, copy form; all entries must be on the form.)

Name		Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)	
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)	
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)	
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
<input type="checkbox"/> NOT APPLICABLE	Signature Required if Not Applicable		



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SECTION 3:

Ownership in Other Disclosing Entities (ODE) (per 42 CFR, Part 455.104 (b)(3)) – (Complete if any identified in Section 1 has an ownership or control interest in ODE)

Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
<input type="checkbox"/> NOT APPLICABLE	Signature Required if Not Applicable	

SECTION 4:

Ownership in Subcontractors If the Applicant has an ownership or control interest of 5% or more in a subcontractor and an Owner of the Applicant also has an ownership or control interest in the subcontractor, complete the boxes below. If those identified in this Section have a familial relationship with a person with ownership or control interest in one of these subcontractors, complete Section 4).

Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
<input type="checkbox"/> NOT APPLICABLE	Signature Required if Not Applicable	



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SECTION 5:

Familial Relationship in Subcontractors (Complete if those identified in Section 3 have a familial relationship (parent, child sibling spouse))

Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
<input type="checkbox"/> NOT APPLICABLE	Signature Required if Not Applicable	

SECTION 6:

Respond to these questions on behalf of:

1. The Applicant
2. All individuals and entities identified in Sections 1 & 5.
3. Any entity in which the Applicant has a 5% or more ownership.

1. Have any of the individuals/entities (1,2 and 3) been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in Maryland or in any other State, Medicare, or any other governmental or private medical insurance program?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

2. Have any of the individuals/entities (1,2 and 3) ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____



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3. Have any of the individuals/entities (1,2 and 3) ever had their business or professional license or certification, or the license of an entity in which they had an ownership interested over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

4. Is there currently pending any proceedings that could result in the above stated sanctions for the individuals/entities (1, 2 and 3)?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

SIGNATURE AND AFFIRMATION

An application is not considered complete unless the applicant signs below. Failure to provide a signature will cause the application to be returned.

I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary of the Department of Health and Human Services, or the Maryland Department of Health and Mental Hygiene, full and complete information will be supplied within 35 days of the date of the request, concerning:

- A. The ownership of any subcontractor with which the Title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of \$25,000.00 and
- B. Any significant business transactions², occurring during the 5 year period ending on the date of such request, between the Provider and any wholly-owned supplier³ or any subcontractor.

Authorized Signature (No Stamps) **Date**

Position (Type or Print)

² "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of \$25,000 or 5 percent of the total operating expense of a provider.

³ "Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g. a commercial laundry, a manufacturer of hospital bed, or a pharmaceutical firm).



Provider Agreement for Participation in Maryland Medical Assistance Program

This Agreement (the “Agreement”), entered into between the Maryland State Department of Health and Mental Hygiene (the “Department”) and

(Provider Name)

the undersigned Provider or Provider Group and its members or Practitioner(s) (hereinafter called the “Provider”), is made pursuant to Title XIX and Title XXI of the Social Security Act, Health-General, Title 15, Annotated Code of Maryland and state regulations promulgated thereunder to provide medical, healthcare, and home- and community-based services and/or remedial care and services (“Service(s)”) to eligible Maryland Medical Assistance recipients (“Recipient(s)”). On its effective date, this Agreement supersedes and replaces any existing contracts between the parties related to the provision of Services to Recipients.

I. THE PROVIDER AGREES:

- A. To comply with all standards of practice, professional standards and levels of Service as set forth in all applicable federal and state laws, statutes, rules and regulations, as well as all administrative policies, procedures, transmittals, and guidelines issued by the Department, including but not limited to, verifying Recipient eligibility, obtaining prior authorizations, submitting accurate, complete and timely claims, and conducting business in such a way the Recipient retains freedom of choice of providers. The Provider acknowledges his, her or its responsibility to become familiar with those requirements as they may differ significantly from those of other third party payor programs;
- B. To maintain adequate medical, financial and administrative records that fully justify and describe the nature and extent of all goods and Services provided to Recipients for a minimum of six years from the date of payment or longer if required by law. The Provider agrees to provide access upon request to its business or facility and all related Recipient information and records, including claims records, to the Department, the Medicaid Fraud Control Unit (MFCU) of the Maryland Attorney General’s Office, the U.S. Department of Health and Human Services, and/or any of their respective employees, designees or authorized representatives. This requirement does not proscribe record requirements by other laws, regulations, or agreements. It is the Provider’s responsibility to obtain any Recipient consent required to provide the Department, its designee, the MFCU, federal employees, and/or designees or authorized representatives with requested information and records or copies of records. Failure to timely submit or failure to retain adequate documentation for services billed to the Department may result in recovery of payments for Services not adequately documented, and may result in the termination or suspension of the Provider from participation as a Medical Assistance provider.



Provider Agreement for Participation in Maryland Medical Assistance Program

1. Original records must be made available upon request during on-site visits by Department personnel or personnel of the Department's designee.
 2. Copies of records must be timely forwarded to the Department upon written request;
- C. To protect the confidentiality of all Recipient information in accordance with the terms, conditions and requirements of the health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and regulations adopted thereunder contained in 45 CFR 160, 162 and 164, and the Maryland Confidentiality of Medical Records Act (Md. Ann. Code, Health-General §§4-301 *et seq.*);
- D. To provide services on a non-discriminatory basis and to hold harmless, indemnify and defend the Department from all negligent or intentionally detrimental acts of the Provider, its agents and employees. The Provider will not discriminate on the basis of race, color, national origin, age, religion, sex, disabilities, or sexual orientation;
- E. To provide Services in compliance with the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and their respective accompanying regulations, and ensure that qualified individuals with disabilities are given an opportunity to participate in and benefit from its Services, including providing interpretive services for the deaf and hard of hearing when required;
- F. To check the Federal List of Excluded Individuals/Entities on the Health and Human Services (HHS) Office of Inspector General (OIG) website prior to hiring or contracting with individuals or entities and periodically check the OIG website to determine the participation/exclusion status of current employees and contractors. To check the Federal System for Award Management (SAM) prior to hiring or contracting with individuals or entities and periodically check the SAM website to determine the participation/exclusion status of current employees and contractors. To check the Maryland Medicaid List of Excluded Providers and Entities prior to hiring or contracting with individuals or entities and periodically check the website to determine the participation/exclusion status of current employees and contractors. The Provider further agrees to not knowingly employ, or contract with a person, partnership, company, corporation or any other entity or individual that has been disqualified from providing or supplying services to Medical Assistance Recipients unless the Provider receives prior written approval from the Department;



Provider Agreement for Participation in Maryland Medical Assistance Program

- G. To accept the Department's payments as payment in full for covered Services rendered to a Recipient. The Provider agrees not to bill, retain, or accept any additional payment from any Recipient. If the Department denies payment or requests payment from the Recipient, or if the Department denies payment or requests repayment because an otherwise covered Service was not medically necessary or was not preauthorized (if required), the Provider agrees not to seek payment from the Recipient for that Service. The Provider further agrees to immediately repay the Department in full for any claims where the Provider received payment from another party after being paid by the Department;
- H. With the exception of prenatal care or preventive pediatric care, to seek payment from a Recipient's other insurances and resources of payment before submitting claims to the Department, which includes but is not limited to seeking payment from Medicare, private insurance, medical benefits provided by employers and unions, worker compensation, and any other third party insurance. If payment is made by both the Department and the Recipient's other insurance, the Provider shall refund the Department, within 60 days of receipt, the amount paid by the Department;
- I. To accept responsibility for the validity and accuracy of all claims submitted to the Department, whether submitted on paper, electronically or through a billing service;
- J. That all claims submitted under his, her or its provider number shall be for medically necessary Services that were actually provided as described in the claim. The Provider acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions. This may include his, her or its expulsion from the Maryland Medical Assistance Program and/or referrals by the Department to the HHS OIG for expulsion from the Medicare program;
- K. That if Provider is a physician, he or she will, upon request, submit the name and applicable licensure for each physician extender in his or her employment. The Provider is responsible for knowing and complying with the Maryland Medical Assistance Program's definition of an eligible physician extender and for providing supervision as required by the Maryland Medical Assistance Program;
- L. That in case of a group provider, the individual Provider rendering the service shall include his or her own provider number, as well as the group provider number, on any claim;



Provider Agreement for Participation in Maryland Medical Assistance Program

- M. To furnish the Department, within 35 days of the Department's request, full and complete information about:
1. The ownership of any subcontractor with who the Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request;
 2. Any significant business transaction between the Provider and any wholly-owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request; and
 3. Any ownership interest exceeding 5 percent held by the Provider in any other Medical Assistance Provider;
- N. That before the Department enters into or renews this Agreement, the Provider agrees to disclose the identity of any person who:
1. Has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider; and
 2. Has been convicted of a criminal offense related to that person's involvement in the Medicaid or Medicare programs;
- O. To exhaust all administrative remedies prior to initiating any litigation against the Department;
- P. Upon receipt of notification that the Provider is disqualified through any federal, state and/or Medicaid administrative action, to not submit claims for payment to the Department for Services performed after the disqualification date;
- Q. Any excessive payments to a Provider may be immediately deducted from future Department payments to any payee with the Provider's tax identification number, at the discretion of the Department;
- R. Continuation of this Agreement beyond the current term is subject to and contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State legislature and/or federal sources. The Department may terminate this Agreement and the Provider waives any and all claim(s) for damages, effective immediately upon receipt of written notice (or any date specified therein) if for any reason the Department's funding from State and/or federal sources is not appropriated or is withdrawn, limited or impaired;



Provider Agreement for Participation in Maryland Medical Assistance Program

- S. To comply with the Deficit Reduction Act of 2005 (DRA) employee education requirement imposed upon any entity, including any governmental agency, organization, unit, corporation, partnership or other business arrangement (including any Medicaid MCO), whether for profit or not for profit, which receives annual Medicaid Payments of at least \$5,000,000.

- T. For Provider Groups Only: The Provider Group affirms that it has authority to bind all member Providers to this Agreement and that it will provide each member Provider with a copy of this Agreement. The Provider Group also agrees to provide the Department with names and proof of current licensure for each member Provider as well as the name(s) of individual (s) with authority to sign billings on behalf of the group. The Provider Group agrees to be jointly responsible with any member Provider for contractual or administrative sanctions or remedies including, but not limited to reimbursement, withholding, recovery, suspension, termination or exclusion on any claims submitted or payment received. Any false claims, statements or documents, concealment or omission of any material facts may be prosecuted under applicable federal or state laws.

- U. To notify the Department within five (5) working days of any of the following:
 - 1. Any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications, permits or staff privileges by any entity under which a Provider is authorized to provide Services including indictment, arrest, felony conviction or any criminal charge;

 - 2. Change in corporate entity, servicing locations, mailing address or addition to or removal of practitioners or any other information pertinent to the receipt of Department funds; or

 - 3. Change in ownership including full disclosure of the terms of the sales Agreement. When there is a change in ownership this Agreement is automatically assigned to the new owner, and the new owner shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Department, and such amounts may be withheld from the payment of claims submitted when determined. (NOTE: Section I.S.3 does not apply to Nursing Home Providers)

II. THE DEPARTMENT AGREES:

- A. To reimburse the Provider for medically necessary Services provided to Recipients that are covered by the Maryland Medical Assistance Program. Services will be reimbursed in accordance with all Program regulations and fee schedules as reflected in the Code of Maryland Regulations or other rules, action transmittals or guidance issued by the Department; and



Provider Agreement for Participation in Maryland Medical Assistance Program

B. To provide notice of changes in Program regulations through publication in the Maryland Register.

III. THE DEPARTMENT AND PROVIDER MUTUALLY AGREE:

A. That except as specifically provided otherwise in applicable law and regulations, either party may terminate this Agreement by giving thirty (30) days notice in writing to the other party. After termination, the Provider shall notify Recipients, before rendering additional Services, that he or she is no longer a Maryland Medical Assistance participating Provider;

B. That the effective date of this Agreement shall be _____, provided that the Department verifies the information in the Provider’s application. This Agreement shall remain in effect until either party terminates the Agreement (as described in Section III A). Following termination of this Agreement, the Provider must continue to retain records and reimburse the Maryland Medical Assistance Program for overpayments as described in this Agreement and as required by law, including but not limited to Maryland Health-General § 4-403;

C. That no employee of the State of Maryland, whose duties include matters relating to this Provider’s Agreement, shall at the same time become an employee of the Provider without the written permission of the Department;

D. That this Agreement is not transferable or assignable;

E. That the Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this Agreement and is a part hereof as though fully set forth herein; and

Provider Signature (No stamps) Date

Susan J. Tucker

Department Authorization Date

Provider Name (Type or Print) Date

[Signature]

Assistant Attorney General Date

Provider Address (Type or Print)



ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

To enroll in Scion Dental's EFT payment program, please fill out this form and you **must return this form with a voided check or the agreement will not be valid.**

PART I – REASON FOR SUBMISSION

Reason for Submission: New EFT Authorization Revision to Current EFT setup (e.g. account or bank changes)

PART II – PROVIDER OR SUPPLIER INFORMATION

Name of Payee: _____

Tax Identification Number: (Designate SSN or EIN) _____

Address of Payee (City, State, Zip): _____

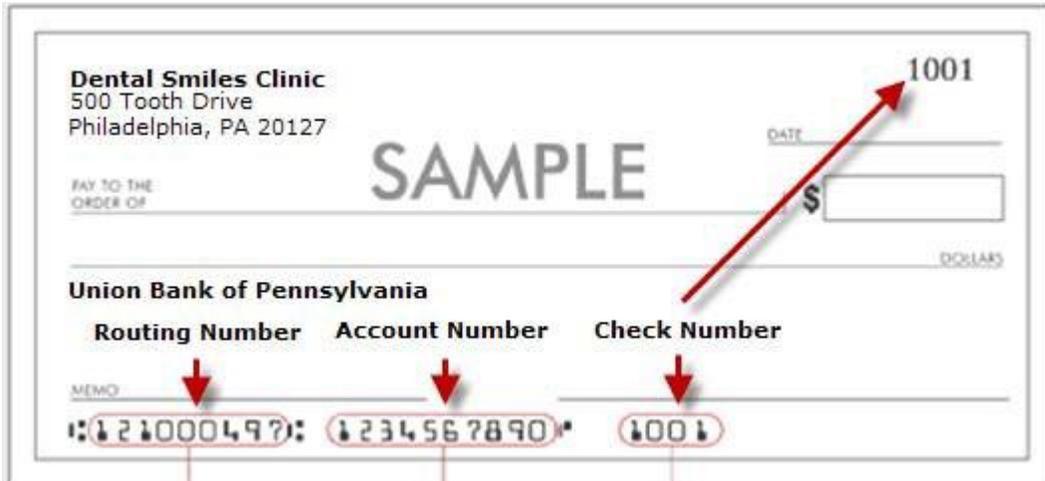
PART III – DEPOSITORY INFORMATION (Financial Institution)

Bank/Depository Name _____

Depository Routing Transit Number (nine digits – include any leading zeros) _____

Depositor Account Number (up to 10 digits – include any leading zeros) _____

Type of Account (check one) Checking Account Savings Account



PART IV – CONTACT INFORMATION

Name of Billing Contact: _____

Phone Number of Billing Contact: _____

Email Address of Billing Contact: _____

PART V – AUTHORIZATION

I hereby authorize Scion Dental on to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit the same to such account. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY a reasonable opportunity to act on it. The CONTRACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the CONTRACTOR an updated EFT Authorization Agreement.

Signature of Authorized Billing Contact: _____ Date: _____

ELECTRONIC FUNDS TRANSFER (EFT)

Terms of Use

The following terms and conditions, as amended from time to time, ("Agreement") apply to all use of the Scion Dental, Inc.'s ("Scion") Electronic Funds Transfer solution, and the use of any service provided in connection therewith (collectively the "EFT Services"). In this Agreement, the words "you", "your" and "yours" means the individual(s) entity or entities identified on the attached Electronic Fund Transfer (EFT) Authorization Agreement, and the words "we," "our," "us" refers to Scion affiliates and designees. Your enrollment or use of the EFT Services signifies your agreement to be legally bound by the terms and conditions set forth herein.

ACH and Wire Transfers. This Agreement is subject to Article 4A of the Uniform Commercial Code -- Funds Transfer. By signing this Agreement, you authorize Scion, acting directly or indirectly on behalf of or through, any third party administrator, health care coalition, or health plan carrier, or other third party carrier or payer (each a "Carrier") that participates in the EFT Services, to credit or debit the account(s) listed on your Enrollment Form (the "Account" or "Accounts") in connection with processing transactions between you and the Carrier. We may rely upon all Account information and identifying numbers provided by you on the Authorization Agreement to receive payment. We may rely on the routing and account numbers you provided even if they identify a financial institution, person or account other than the one named on the Enrollment Form. You agree to be bound by all applicable law, rules and guidelines related to electronic funds transfers, including, without limitation, 31 CFR Part 210, Article 4A of the UCC and the Automated Clearing House (ACH) Association Rules. The ACH rules provide, among other things, that payments made to you, or originated by you, are provisional until final settlement is made through a Federal Reserve Bank or payment is otherwise made as provided in Article 4A-403(a) of the UCC. If we do not receive such payment, we are entitled to a refund from you in the amount credited to your Account and the Carrier that originated or instructed such payment will not be considered to have paid the amount so credited. We are not required to give you any notice of debits or credits to your Accounts. We may make adjustments to your Accounts whenever a correction or change is required. For example, if we make an error with respect to your Account, you agree that we may correct such error immediately and without notice to you. Such errors may include, but are not limited to, reversing an improper credit to your Account, making adjustments for returned items, and correcting calculation and input errors. Our right to make adjustments shall not be subject to any limitations or time constraints, except as required by law.

Accounts. You represent and warrant that (a) you are the owner of each of the Accounts and (b) none of the Accounts is used primarily for personal, family or household purposes.

Disclosures of Account Information to Others. We may disclose information to third parties about you and your Account(s) and transactions as follows: (i) pursuant to agreements with third parties that assist us in the provision of EFT Services; (ii) to verify the existence and condition of an Account; and (iii) as otherwise necessary for us to provide services or facilitate payments to you.

Amendments and Termination. Scion may add, remove, change or otherwise modify any term of this Agreement at any time. We may also terminate or discontinue some or all of the EFT Services at any time without notice to you.

Governing Law and Venue. The laws of the State of Wisconsin shall govern this Agreement and all disputes arising hereunder. You hereby consent that jurisdiction and venue are proper in the State of Wisconsin for the resolution of any dispute arising under this Agreement.

Severability. If any provision of this Agreement is found to be unenforceable according to its terms, all remaining provisions will continue in full force and effect.

Cooperation. You agree to cooperate fully with us in furnishing any information, documentation or performing any action requested by us. You shall furnish us, upon forty-eight (48) hours' notice, with true, accurate and complete copies of such records, documentation or any other information we or our authorized employees, representatives, agents and any regulatory agencies may request; provided, however, that you shall not be required to divulge any records to the extent prohibited by applicable law.

Ownership. Except as provided in this Agreement, Scion shall have and own all rights, title and interests in the EFT Services and any information arising from or in connection therewith. You hereby acknowledge the specific ownership interests of Scion as set forth herein and you shall not acquire any ownership rights by virtue of this Agreement.

Relationship of the Parties. The relationship between both parties under this Agreement is that of independent parties contracting at an arm's-length with each other. Nothing herein contained shall be construed as constituting a partnership, joint venture or agency between the parties hereto.

Entire Agreement. This Agreement constitutes the only agreement between the parties hereto relating to the subject matter hereof, except where expressly noted herein, and all prior negotiations, agreements and understandings relating to the subject matter hereof, whether oral or written, are superseded or canceled hereby.

Force Majeure. Scion shall not be liable for a delay in performance or failure to perform any obligation under this Agreement to the extent such delay is due to causes beyond our control, including, but not limited to, governmental requests, regulations or orders, utility or communications failure, delays in transportation, national emergency, war, civil commotion or disturbance, war conditions, fires, floods, storms, earthquakes, tidal waves, failure or delay in receiving electronic data, equipment or systems failure or communication failures.

Warranties, Indemnification and Limitation of Liability. SCION HEREBY DISCLAIMS ALL WARRANTIES WITH RESPECT TO THE SERVICES AND PRODUCTS PROVIDED HEREUNDER, WHETHER EXPRESS, IMPLIED, STATUTORY OR OTHERWISE, INCLUDING, WITHOUT LIMITATION, ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR USE FOR A PARTICULAR PURPOSE. Scion is entering into this agreement as an accommodation and convenience to you, and you will indemnify and hold Scion free and harmless from and against any and all claims, demands, actions, suits damages and costs, whether groundless or otherwise, whether based on contract, negligence or otherwise, and as may arise out of any act or failure to act on the part of Scion. Scion shall incur no liability to you or any other person in the event the intended party does not receive the funds if Scion shall have acted reasonably in transmitting the funds in accordance with your instructions. Scion shall not be held liable or responsible for failures, delays, errors, claims or damages in the execution or effectuation of any transfer occasioned by the fault or negligence of any correspondent bank, agent, or agency for purposes of making or completing transfer of funds. IN NO EVENT SHALL SCION, ITS PARENT, AFFILIATES, SUBSIDIARIES, DIRECTORS, OFFICERS, EMPLOYEES, AGENTS OR REPRESENTATIVES BE LIABLE FOR SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES OR CLAIMS BY YOU OR ANY THIRD PARTY RELATIVE TO THE TRANSACTIONS HERE UNDER.



Application for Participation in Maryland Medical Assistance Program INDIVIDUAL DENTAL ADDENDUM

Professional / Medical Specialty Information																	
Primary Specialty	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 2px;">SPECIALTY CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td style="width: 30%; padding: 2px;">INITIAL CERTIFICATION DATE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td style="width: 30%; padding: 2px;">DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?</td> <td style="width: 10%; padding: 2px;">HMO <input style="width: 20px; height: 20px;" type="checkbox"/> YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO</td> </tr> <tr> <td style="padding: 2px;">BOARD CERTIFIED? <input style="width: 20px; height: 20px;" type="checkbox"/> YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO</td> <td style="padding: 2px;">RECERTIFICATION DATE (IF APPLICABLE) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 2px;">PPO <input style="width: 20px; height: 20px;" type="checkbox"/> YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO</td> <td style="padding: 2px;">POS <input style="width: 20px; height: 20px;" type="checkbox"/> YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO</td> </tr> <tr> <td style="padding: 2px;">CERTIFYING BOARD CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 2px;">EXPIRATION DATE (IF APPLICABLE) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></td> <td colspan="2"></td> </tr> </table> <p style="font-size: small; margin-top: 10px;"> <input type="checkbox"/> IF NOT BOARD CERTIFIED (SELECT ONE) I HAVE TAKEN EXAM, RESULTS PENDING FOR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> CERTIFYING BOARD CODE <input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON <input style="width: 20px; height: 20px;" type="text"/> <input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM. </p> <p style="font-size: x-small; margin-top: 5px;">IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.</p> <div style="border: 1px solid #ccc; height: 40px; width: 100%;"></div>	SPECIALTY CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	INITIAL CERTIFICATION DATE <input style="width: 20px; height: 20px;" type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO <input style="width: 20px; height: 20px;" type="checkbox"/> YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO	BOARD CERTIFIED? <input style="width: 20px; height: 20px;" type="checkbox"/> YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO	RECERTIFICATION DATE (IF APPLICABLE) <input style="width: 20px; height: 20px;" type="text"/>	PPO <input style="width: 20px; height: 20px;" type="checkbox"/> YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO	POS <input style="width: 20px; height: 20px;" type="checkbox"/> YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO	CERTIFYING BOARD CODE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	EXPIRATION DATE (IF APPLICABLE) <input style="width: 20px; height: 20px;" type="text"/>						
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E-MAIL ADDRESS <input style="width: 100%; height: 20px;" type="text"/>																	



Application for Participation in Maryland Medical Assistance Program INDIVIDUAL DENTAL ADDENDUM

Office Information

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	FRIDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TUESDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SATURDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
WEDNESDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SUNDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
THURSDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					

NOTE:
After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?*	IF YES	ANSWERING SERVICE	VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE	VOICE MAIL WITH OTHER INSTRUCTIONS	AFTER HOURS BACK OFFICE TELEPHONE
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ACCEPT ALL NEW PATIENTS?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ACCEPT NEW MEDICARE PATIENTS?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ACCEPT NEW MEDICAID PATIENTS?*	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)	<input type="text"/>				
ARE THERE ANY PRACTICE LIMITATIONS?*	<input type="text"/>				
	GENDER LIMITATIONS	AGE LIMITATIONS	LIST OTHER LIMITATIONS		
<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES <input type="checkbox"/> MALE ONLY <input type="checkbox"/> NONE	<input type="checkbox"/> MINIMUM AGE	<input type="text"/>		
	<input type="checkbox"/> FEMALE ONLY	<input type="checkbox"/> MAXIMUM AGE	<input type="text"/>		



Application for Participation in Maryland Medical Assistance Program INDIVIDUAL DENTAL ADDENDUM

Professional Liability Insurance Carrier	
Professional Liability Insurance Carrier	<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>CARRIER OR SELF-INSURED NAME*</small> </div> <div style="width: 15%;"> <small>SELF-INSURED?*</small> YES <input type="checkbox"/> NO <input type="checkbox"/> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>NUMBER*</small> </div> <div style="width: 50%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>STREET*</small> </div> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>SUITE/BUILDING</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>CITY*</small> </div> <div style="width: 15%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>STATE*</small> </div> <div style="width: 60%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>ZIP CODE*</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>ORIGINAL EFFECTIVE DATE*</small> </div> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>EFFECTIVE DATE*</small> </div> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>EXPIRATION DATE</small> </div> <div style="width: 25%;"> <small>TYPE OF COVERAGE?*</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 45%;"> <small>DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?*</small> YES <input type="checkbox"/> NO <input type="checkbox"/> </div> <div style="width: 5%;"> <small>\$</small> </div> <div style="width: 30%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>AMOUNT OF COVERAGE PER OCCURRENCE</small> </div> <div style="width: 5%;"> <small>\$</small> </div> <div style="width: 35%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>AMOUNT OF COVERAGE AGGREGATE</small> </div> </div> <div style="margin-top: 5px;"> <small>POLICY INCLUDES TAIL COVERAGE?</small> YES <input type="checkbox"/> NO <input type="checkbox"/> </div> <div style="margin-top: 5px;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>POLICY NUMBER*</small> </div>
Professional Liability Insurance Carrier <small>List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.</small> <small>NOTE: A longer period may be required by your healthcare entity.</small>	<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>CARRIER OR SELF-INSURED NAME</small> </div> <div style="width: 15%;"> <small>SELF-INSURED?*</small> YES <input type="checkbox"/> NO <input type="checkbox"/> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>NUMBER*</small> </div> <div style="width: 50%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>STREET*</small> </div> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>SUITE/BUILDING</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>CITY*</small> </div> <div style="width: 15%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>STATE*</small> </div> <div style="width: 60%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>ZIP CODE*</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>ORIGINAL EFFECTIVE DATE*</small> </div> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>EFFECTIVE DATE*</small> </div> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>EXPIRATION DATE</small> </div> <div style="width: 25%;"> <small>TYPE OF COVERAGE?*</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 45%;"> <small>DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?*</small> YES <input type="checkbox"/> NO <input type="checkbox"/> </div> <div style="width: 5%;"> <small>\$</small> </div> <div style="width: 30%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>AMOUNT OF COVERAGE PER OCCURRENCE</small> </div> <div style="width: 5%;"> <small>\$</small> </div> <div style="width: 35%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>AMOUNT OF COVERAGE AGGREGATE</small> </div> </div> <div style="margin-top: 5px;"> <small>POLICY INCLUDES TAIL COVERAGE?</small> YES <input type="checkbox"/> NO <input type="checkbox"/> </div> <div style="margin-top: 5px;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>POLICY NUMBER*</small> </div>
Work History and References	
Military Duty	<small>Are you currently on active military duty or military reserve?*</small> YES <input type="checkbox"/> NO <input type="checkbox"/>
Work History <small>Include a chronological work history for the past 10 years.</small> <small>A longer period may be required by your healthcare entity.</small>	WORK HISTORY <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>PRACTICE / EMPLOYER NAME*</small>
	<div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>NUMBER</small> </div> <div style="width: 50%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>STREET</small> </div> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>SUITE/BUILDING</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 25%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>CITY</small> </div> <div style="width: 15%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>STATE</small> </div> <div style="width: 60%;"> <input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> <small>ZIP/POSTAL CODE</small> </div> </div>



Application for Participation in Maryland Medical Assistance Program INDIVIDUAL DENTAL ADDENDUM

	Disclosure Questions
<p>Disclosure Questions</p> <p>Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.</p> <p>Allied Health Providers</p> <p>If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".</p>	<p>LICENSURE</p> <p>1. <input type="checkbox"/> YES <input type="checkbox"/> NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*</p> <p>2. <input type="checkbox"/> YES <input type="checkbox"/> NO Has there been any challenge to your licensure, registration or certification?*</p> <p>HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS</p> <p>3. <input type="checkbox"/> YES <input type="checkbox"/> NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*</p> <p>4. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*</p> <p>5. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*</p> <p>EDUCATION, TRAINING AND BOARD CERTIFICATION</p> <p>6. <input type="checkbox"/> YES <input type="checkbox"/> NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*</p> <p>7. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*</p> <p>8. <input type="checkbox"/> YES <input type="checkbox"/> NO Have any of your board certifications or eligibility ever been revoked?*</p> <p>9. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*</p> <p>DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION</p> <p>10. <input type="checkbox"/> YES <input type="checkbox"/> NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*</p> <p>MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION</p> <p>11. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*</p> <p>OTHER SANCTIONS OR INVESTIGATIONS</p> <p>12. <input type="checkbox"/> YES <input type="checkbox"/> NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*</p> <p>13. <input type="checkbox"/> YES <input type="checkbox"/> NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*</p> <p>14. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*</p> <p>15. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*</p> <p>16. <input type="checkbox"/> YES <input type="checkbox"/> NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*</p> <p>PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY</p> <p>17. <input type="checkbox"/> YES <input type="checkbox"/> NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*</p> <p>18. <input type="checkbox"/> YES <input type="checkbox"/> NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*</p>



Application for Participation in Maryland Medical Assistance Program INDIVIDUAL DENTAL ADDENDUM

Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

IMPORTANT
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation.

MALPRACTICE CLAIMS HISTORY

19. YES NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?*
If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

20. YES NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*
21. YES NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
22. YES NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

23. YES NO Are you currently engaged in the illegal use of drugs?*
("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)
24. YES NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*
25. YES NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*
26. YES NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*



Application for Participation in Maryland Medical Assistance Program INDIVIDUAL DENTAL ADDENDUM

Disclosure Questions

Disclosure Questions

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. Your response should not exceed the spaces provided.

Record the number in the first column, then your explanation in the second column.

Question #	Explanation:

Question #	Explanation:

Question #	Explanation:



Application for Participation in Maryland Medical Assistance Program INDIVIDUAL DENTAL ADDENDUM

Standard Authorization, Attestation and Release

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*