

**Department of Corrections**

**Network Provider**

**Dental**

**Contract**

# TABLE OF CONTENTS

|       |  |   |
|-------|--|---|
| I.    | RECITALS .....   | 1 |
| II.   | DEFINITIONS.....   | 1 |
| III.  | RELATIONSHIP BETWEEN THE DEPARTMENT AND<br>THE DENTIST ..... | 3 |
| IV.   | DENTIST SERVICES AND RESPONSIBILITIES .....                  | 3 |
| V.    | DEPARTMENT SERVICES AND RESPONSIBILITIES .....               | 4 |
| VI.   | COMPENSATION AND BILLING.....                                | 5 |
| VII.  | LIABILITY AND INSURANCE .....                                | 6 |
| VIII. | MARKETING, ADVERTISING AND PUBLICITY .....                   | 6 |
| IX.   | DISPUTE RESOLUTION .....                                     | 7 |
| X.    | TERM AND TERMINATION .....                                   | 7 |
| XI.   | GENERAL PROVISIONS .....                                     | 7 |

APPENDIX:  
SIGNATURE PAGE

# **Oklahoma Department of Corrections Network Provider Dental Contract**

It is hereby agreed between the Oklahoma Department of Corrections and the Dentist named on the signature page, that the Dentist shall be a Provider in the Oklahoma Department of Corrections 's Network of Providers.

This Contract is entered into for the purpose of defining the conditions for reimbursement by the Oklahoma Department of Corrections to the Dentist. It in no way is meant to impact on the Dentist's decision as to what is considered appropriate dental treatment.

## **I. RECITALS**

- 1.1 The Oklahoma Department of Corrections (Department) is a statutory body created by 74 O.S., § 1301 et seq., as amended, to administer and manage certain insurance benefits for employees of the State of Oklahoma.
- 1.2 The Dentist is duly licensed by the state of practice as a practitioner of the dentistry or recognized dental specialty and satisfies additional credentialing criteria as established by the Department.
- 1.3 The intent of this Contract is to provide access to enhanced quality dental care, utilizing managed care components, at an affordable, competitive cost to the Department and its members.
- 1.4 Failure to abide by any of the following provisions may result in non-renewal of the Contract or may be cause for termination.

## **II. DEFINITIONS**

- 2.1 "Allowable Fee" means the maximum charge payable to a Dentist for a specific procedure in accordance with the provisions in Article VI of this Contract. The Dentist shall charge the usual and customary fee unless the fee schedule limits otherwise.
- 2.2 "Credentialing Plan" means a general guide and process for the acceptance, cooperation and termination of participating dentists and other health care providers.

- 2.3 "Emergency" means a sudden onset of an adverse medical or dental condition manifesting itself by acute symptoms that are so severe that the absence of immediate professional attention could reasonably result in serious medical or dental consequences, or causing loss or irreversible damage of the affected part(s).
- 2.4 "HELP/Wellness" (Health Education Lifestyle Planning) means the program established to actively promote responsible behavior and the adoption of lifestyles that are in the best interest of the Plan member's good health.
- 2.5 "Dental" means belonging to the study and practice of dentistry or a dental specialty for the prevention, alleviation or management of an adverse medical/dental condition.
- 2.6 "Medically Necessary" means services or supplies that, under the provisions of this Contract, are determined to be:
- a) appropriate and necessary for the symptoms, diagnosis or treatment of the medical/dental condition, and
  - b) provided for the diagnosis and treatment of the medical/dental condition, and
  - c) within standards of acceptable, prudent dentistry practice within the community, and
  - d) not primarily for the convenience of the member, the member's dentist or another provider, and
  - e) any condition which, if left untreated, could reasonably result in serious medical or dental consequences, or cause loss or irreversible damage of the affected part(s), and
  - f) the most appropriate supply or level of service that can safely be provided.
- 2.7 "Dental Services" means the professional services provided by a Network Dentist and covered by the Oklahoma Department of Corrections.
- 2.8 "Members" means all persons covered by the Oklahoma Department of Corrections, including active, retired, or vested employees, survivors and others on approved leave or disability and their covered dependents eligible at the time of service.
- 2.9 "Network Provider" means a licensed dental practitioner who has entered into this Contract with the Department to accept scheduled reimbursement for covered dental services provided to members.
- 2.10 "Pre-estimation" means the itemization of proposed dental services and the expected charges prior to treatment.

- 2.11 "State and Education Employees Dental Insurance Plan" means the HealthChoice benefit plan designed to enhance the quality of care, and to financially incentivise members to use Network Dentists.
- 2.12 "Third Party Payor" means an insurance company or other entity making payment directly to the Dentist on behalf of the Department.

### **III. RELATIONSHIP BETWEEN THE DEPARTMENT AND THE DENTIST**

- 3.1 The Department has negotiated and entered into this Contract with the Dentist on behalf of the individuals who are members of the State and Education Employees Dental Insurance Plan. The Dentist is an independent contractor who has entered into this Contract to become a Network Dentist and is not, nor is intended to be, the employee, agent or other legal representative of the Department in the performance of the provisions of this Contract. Nothing in this Contract shall be construed or be deemed to create a relationship contrary to that of independent contractor for the purposes of this Contract.
- 3.2 The Department and the Dentist agree that all of the parties hereto shall respect and observe the dentist/patient relationship that will be established and maintained by the Dentist. The Dentist may choose not to establish a dentist/patient relationship if the Dentist would have otherwise made the decision not to establish a dentist/patient relationship had the patient not been a member. The Dentist reserves the right to refuse to furnish services to a member in the same manner as he would any other patient.
- 3.3 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies in any third party, including but not limited to, a member or a Network Dentist other than the Dentist named in this Contract.

### **IV. DENTIST SERVICES AND RESPONSIBILITIES**

- 4.1 The Dentist agrees to provide quality dental care in a cost efficient manner.
- 4.2 For the purpose of reimbursement, the Dentist shall provide services to members that are deemed appropriate, and covered under the Dental Insurance Plan.
- 4.3 The Dentist agrees to make reasonable effort to refer covered members to other Network Providers. Failure of the Dentist to use Network Providers will result in a review pursuant to the credentialing plan.
- 4.4 The Dentist shall prescribe for Department member's medications identified on the adopted formulary or explain, in writing, on behalf of the member to the Department why it is inappropriate to do so.

- 4.5 The Dentist shall accurately complete the Network Provider Application that is attached to and made part of this Contract. The Dentist shall notify the Department's Network Manager of any change in the information contained in the Application within 15 days of such change, including resolved litigation listed as "pending" on the original Application.
- 4.6 The Dentist shall reimburse the Department for any overpayments made to the Dentist within 30 days of the Dentist's receipt of the overpayment notification.
- 4.7 The Dentist shall submit to a patient record audit upon 48 hours advance notice.

## **V. DEPARTMENT SERVICES AND RESPONSIBILITIES**

- 5.1 The Department agrees to pay the Dentist compensation pursuant to the provisions of Article VI, subject to appropriate application of procedural coding recommendations.
- 5.2 The Department agrees to grant the Dentist the status of "Network Provider" and to identify the Dentist as a Network Dentist on informational materials disseminated to members.
- 5.3 The Department agrees to continue listing the Dentist as a Network Provider until this Contract terminates.
- 5.4 The Department agrees to provide the Dentist access to a listing of all Network Providers.
- 5.5 The Department agrees to provide appropriate identification cards for members.
- 5.6 The Department agrees to adhere to confidentiality of patient's records and to only release pertinent clinical information in accordance with state and federal guidelines.
- 5.7 The Department shall give a 48 hour notice prior to an audit.
- 5.8 The Department shall maintain a pre-estimation program in order to aid its members in making decisions that will maximize dental benefits and reduce their financial risk.

## VI. COMPENSATION AND BILLING

- 6.1 The Dentist shall seek payment only from the Department for the provision of dental services except as provided in paragraphs 6.3 and 6.4. The payment from the Oklahoma Department of Corrections shall be limited to the amounts referred to in paragraph 6.2.
- 6.2 The Department agrees to pay the Dentist's billed charge for each procedure or the fee set by the Department for that procedure, whichever is less.
- a) The Department may reduce the payment by any deductibles, coinsurance and copayments.
  - b) The Department shall have the right to categorize what shall constitute a procedure. The Department and the member's financial liability shall be limited to the procedures allowable as determined by the Department, paid by applying appropriate coding methodology, whether the Dentist has billed appropriately or not.
  - c) The Dentist agrees not to charge more for dental services to members than the amount normally charged by the Dentist to other patients for similar services. The Dentist may, however, contract with other third party payors for services. The Dentist's usual and customary charges may be requested by the Department and verified through an audit.
- 6.3 The Dentist agrees that the only charges for which a member may be liable and be billed by the Dentist shall be for dental services not covered by Oklahoma Department of Corrections, or as provided in paragraph 6.4. The Dentist shall not waive any deductibles, copayments and coinsurance required by the Department, except during times of HELP/Wellness promotions, when the copayment/coinsurance is waived by the Department.
- 6.4 The Dentist shall not collect amounts in excess of the Plan limits unless the member has exceeded his/her annual or lifetime maximum.
- 6.5 The Dentist shall refund within 30 days of discovery to the member any overpayments made by the member.
- 6.6 In a case in which the Department is primary under applicable coordination of benefit rules, the Department shall pay the amounts due under this Contract. In a case in which the Department is other than primary under the coordination of benefit rules, the Department shall pay only those amounts not payable from other sources pursuant to the applicable coordination of benefit rules, up to the Department's maximum liability under the terms of this Contract.

- 6.7 The Dentist shall bill the Department on forms acceptable to the Department within 60 days of providing the dental services. The Dentist shall use the current ADA codes or CPT codes when appropriate. The Dentist shall furnish, upon request at no cost, all information, including dental records and x-rays, reasonably required by the Department to verify and substantiate the provision of dental services and the charges for such services if the member and the Dentist are seeking reimbursement through the Department.
- 6.8 The Department shall reimburse the Dentist within 30 days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this Contract. The Department will not be responsible for delay of reimbursement due to circumstances beyond the Department 's control.
- 6.9 The Department shall have the right at all reasonable times and to the extent permitted by law to inspect and duplicate all dental billing records relating to dental services rendered to covered members at no cost to the Department or the member.

## **VII. LIABILITY AND INSURANCE**

- 7.1 Neither party to this Contract, the Department nor the Dentist, nor any agent, employee or other representative of a party, shall be liable to third parties for any negligent act by commission or omission of the other party in performance of this Contract and the terms and provisions herein.
- 7.2 The Dentist, at his/her sole expense, shall maintain a minimum of \$1,000,000 per occurrence and \$1,000,000 aggregate of insurance coverage for professional liability.

## **VIII. MARKETING, ADVERTISING AND PUBLICITY**

- 8.1 The Department shall encourage its members to use the services of the Network Dentist.
- 8.2 The Department shall have the right to use the name, office address, telephone number and specialty of the Dentist for purposes of informing its members and prospective members of the identity of the Network Providers.
- 8.3 The Dentist, upon prior approval of the Department, shall have the right to publicize the Dentist's status in the Department's Network of Providers.

**IX. DISPUTE RESOLUTION**

- 9.1 The Department and the Dentist agree that their authorized representatives will meet in a timely manner and negotiate in good faith to resolve any problems or disputes that may arise in performance of the terms and provisions of this Contract. Nothing in this Article shall interfere with either party's rights under Article X.

**X. TERM AND TERMINATION**

- 10.1 The term of this Contract shall commence on the effective date on the signature page, and shall remain in effect until terminated by either party subject to 10.2.
- 10.2 Either party may terminate this Contract with or without cause, upon giving 30 day notice pursuant to 11.2.
- 10.3 Nothing in this Contract shall be construed to limit either party's remedies at law or in equity in the event of a material breach of this Contract.
- 10.4 This Contract shall terminate with respect to a Dentist upon:
- a) the loss or suspension of the Dentist's license to practice medicine in the state of practice; or
  - b) failure to maintain Dentist's professional liability insurance in accordance with this Contract.
- 10.5 Following the effective date of termination, this Contract shall be of no further force or effect, except that each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to the effective date of termination of this Contract.
- 10.6 Following termination of this Contract, the Department shall continue to have access to the Dentist's records of care and services provided to members for five years from the date of provision of the services to which the records refer as set forth in Paragraph 6.9.

**XI. GENERAL PROVISIONS**

- 11.1 This Contract or any of the rights, duties, or obligations of the parties hereunder, shall not be assigned by either party without the express written consent and approval of the other party.

- 11.2 At any place within this Contract that notice is required, it is the intention of the parties that only those with regard to termination by either party of participation in the Contract must be sent by certified mail, a return receipt requested, at no other time when notice is required by this Contract is there an obligation by either party to use certified mail.
- 11.3 Notwithstanding the provisions of Paragraph 11.1 of this Contract, the Department may appoint an Administrator to administer any of the terms of the Network Contract referenced herein, and any and all duties or acts required of the Department under this Contract and to receive any notices required by this Contract.
- 11.4 This Contract, together with its exhibits, contains the entire agreement between the Department and the Dentist relating to the rights granted and the obligations assumed by the parties concerning the provision of dental services to members. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Contract not expressly set forth in this Contract are of no force or effect.
- 11.5 This Contract, or any part, section or exhibit of, or attached to it, may be amended at any time during the term of the Contract by mutual written consent of duly authorized representatives of the Department and the Dentist.
- 11.6 This Contract is subject to all applicable Oklahoma State Statutes and Rules and Regulations. Any provision of this Contract that is not in conformity with existing or future legislation shall be considered amended to comply with such legislation. Any interpretations or disputes with respect to contract provisions shall be resolved in accordance with the laws of the State of Oklahoma.
- 11.7 The terms and provisions of this Contract shall be deemed to be severable one from the other, and the determination at law or in a court of equity that one term or provision is unenforceable, shall have no effect on the remaining terms and provisions of this entire Contract, or any one of them, in accordance with the intent and purpose of the parties hereto.

**Department of Corrections  
Network Dentist  
Application Requirements**

---

Thank you for your interest in the Department of Corrections (DOC) Provider Network.

Please complete the attached Application and submit with the required attachments listed below.

Type or print your responses and complete all sections of the Application. If an area of inquiry is not applicable to you or your practice, please indicate. If you need additional space to provide COMPLETE answers, attach additional sheets of paper and clearly indicate the item to which each sheet applies.

***Retain the contract for your records.***

**REQUIRED ATTACHEMENTS**

**Please attach a copy of each of the following documents to your completed Application:**

**Current state(s) license(s)**

**Current DEA registrations (narcotics license), if applicable**

**Current state narcotics registration, if applicable**

**Face Sheet of current professional liability insurance policy**

Insurance certificate/Face Sheet must have the name of the applicant listed as the insured. The insurance limits must be at the level required in the Contract and must indicate clearly that it is professional liability coverage.

**W-9 form for each Federal Tax ID Number**

W-9 forms must be signed and list only the Federal Tax ID Number or Social Security Number for each location listed on the Application which will be used on claim forms submitted to DOC.

**Contract Signature Page**

**Incomplete Applications will be returned**

---

State of Oklahoma

**DEPARTMENT OF CORRECTIONS**  
**Network Dentist**  
**Application**

---

The completed Network Provider Application should be returned to the Department of Corrections in its entirety, along with any applicable attachments.

You may mail or fax the Application to:

Oklahoma Department of Corrections  
ATTN: Provider Relations/Network Management  
P.O. Box 12878  
Oklahoma City, OK 73112  
Phone: 405-717-8750 or 1-800-573-8462  
Fax: 405-717-8977

---

---

**GENERAL INFORMATION**

---

---

Dentist's Name: \_\_\_\_\_  
(Last) (First) (Middle)

*If your name has changed during the past twenty-four (24) months, please indicate all names you have used on licenses, registrations, etc:* \_\_\_\_\_

Social Security Number: \_\_\_\_\_

National Provider Identifier Number: \_\_\_\_\_

---

---

**SPECIALTY INFORMATION**

---

---

Profession/License: \_\_\_\_\_

Primary Specialty: \_\_\_\_\_

Secondary Specialty: \_\_\_\_\_

Provide the following information for each state in which you have obtained professional licensure:

State: \_\_\_\_\_ License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

State: \_\_\_\_\_ License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

State: \_\_\_\_\_ License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

---

---

## INSURANCE INFORMATION

---

---

**(Minimum requirements of \$1,000,000 per occurrence and \$1,000,000 aggregate)**

Please provide the following information about your current professional liability insurance coverage:

Name of Carrier: \_\_\_\_\_  
(Please attach a copy of the Insurance Certificate/Face Sheet)

Coverage Amounts:

Per Occurrence \_\_\_\_\_ Aggregate: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

---

---

## STAFF PRIVILEGES

---

---

Identify all hospitals at which you have current privileges (if applicable):

Hospital: \_\_\_\_\_

Address \_\_\_\_\_ Status: \_\_\_\_\_

## OFFICE INFORMATION

Federal Tax ID Number: \_\_\_\_\_  
(Attach a completed W-9 form for each Federal Tax ID Number)

## PHYSICAL ADDRESS – Physical Location of Practice

**THIS PRACTICE ADDRESS AND PHONE NUMBER WILL APPEAR ON OUR WEBSITE** Primary  
Office or clinic name: \_\_\_\_\_

Physical Address: \_\_\_\_\_

(City)

(State)

(Zip)

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

## MAILING ADDRESS – for Correspondence/Credentialing

Mailing Office or clinic name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

(City)

(State)

(Zip)

Credentialing/Contact Person: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

## BILLING/REMIT ADDRESS – for Claims Payments and EOBs

**ALL BILLING INFORMATION BELOW MUST MATCH SUBMITTED CLAIMS**

Name submitted on claims: \_\_\_\_\_

Billing Office or clinic name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

(City)

(State)

(Zip)

Contact Person: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

## ADDITIONAL OFFICE LOCATION(S)

Federal Tax ID Number: \_\_\_\_\_  
(Attach a completed W-9 form for each Federal Tax ID number)

### PHYSICAL ADDRESS – Physical Location of Practice

THIS PRACTICE ADDRESS AND PHONE NUMBER WILL APPEAR ON OUR WEBSITE Primary  
Office or clinic name: \_\_\_\_\_

Physical Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip)

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

### MAILING ADDRESS – for Correspondence/Credentialing

Mailing Office or clinic name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip)

Credentialing/Contact Person: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

### BILLING/REMIT ADDRESS – for Claims Payments and EOBs

**ALL BILLING INFORMATION BELOW MUST MATCH SUBMITTED CLAIMS**

Name submitted on claims: \_\_\_\_\_

Billing Office or clinic name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip)

Contact Person: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

**\*Please use a copy of this page to report any additional locations.**

OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD



Oklahoma Department  
of Rehabilitation Services



Department of Corrections  
Oklahoma

**Electronic Funds Transfer (EFT) Form**

**SUPPLIER ONLY:**

Legal Name of Corporate Owner: \_\_\_\_\_

Trade Name/dba: \_\_\_\_\_ Federal Tax ID #: \_\_\_\_\_

**PRACTITIONER ONLY:**

Practitioner's Name: \_\_\_\_\_

SSN: \_\_\_\_\_ Federal Tax ID #: \_\_\_\_\_

**BANKING INFORMATION**

A voided check is required. If the bank account does not have checks, a bank letter verifying the account and routing numbers will be accepted.

A deposit slip will be accepted only if the information provided below matches the MICR line containing the banking ABA number and account between these symbols | : |:

Financial Institution: \_\_\_\_\_

Account Number: \_\_\_\_\_ Routing Number: \_\_\_\_\_

Checking  Savings

**BILLING/REMIT**

Name Submitted on Claims: \_\_\_\_\_

Billing Office Name (if applicable): \_\_\_\_\_

Billing Address: \_\_\_\_\_

(City)

(State)

(Zip)

**AUTHORIZED SIGNATURE**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Required)

Printed Signature Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please mail, fax or email the completed form to:

OSEEGIB

Attn: Provider Relations

3545 N.W. 58 Street, Suite 600

Oklahoma City, OK 73112

Phone: 1-405-717-8790 or 1-800-543-6044

Fax: 1-405-717-8977

oseegibproviderrelations@sib.ok.gov

---

State of Oklahoma

**Department of Corrections  
Network Dentist Signature  
Page**

---

When signed by both parties below, this constitutes agreement and acceptance of all terms and conditions contained in the Network Dentist Contract. The DOC and the Dentist further agree that the effective date of the Contract is the effective date denoted on the copy of the executed signature Page returned to the Dentist. The original of the signed document will remain on file in the office of the Department. By signing, both parties agree that this document shall become a part of the contract.

**FOR THE DENTIST:**

Signature Date: \_\_\_\_\_

Name (typed or printed):  
\_\_\_\_\_

Signature:  
\_\_\_\_\_  
\_\_\_\_\_

SSN: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_

Primary Service Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR THE BOARD:**

\_\_\_\_\_  
Director or Chief Medical Officer  
Department of Corrections  
3400 M.L. King Avenue  
Oklahoma City, OK 73111

**Please return the completed Application, Signature Page, and required attachments to:**

**Oklahoma State and Education Employees Group Insurance Board  
ATTN: Provider Relations/Network Management  
3545 N.W. 58<sup>th</sup> Street, Suite 600  
Oklahoma City, OK 73112  
Phone: 405-717-8860 or 1-800-543-6044  
Fax: 405-717-8977**