

State of Oklahoma
Department of Correction
Dental
Contract

Table of Contents

I.	RECITALS.....	1
II.	DEFINITIONS.....	1
III.	RELATIONSHIP BETWEEN DEPARTMENT AND THE DENTIST.....	2
IV.	DENTIST SERVICES AND RESPONSIBILITIES.....	2
V.	DEPARTMENT SERVICES AND RESPONSIBILITIES.....	3
VI.	COMPENSATION AND BILLING.....	3
VII.	LIABILITY AND INSURANCE.....	4
VIII.	MARKETING, ADVERTISING AND PUBLICITY.....	4
IX.	DISPUTE RESOLUTION.....	4
X.	TERM AND TERMINATION.....	4
XI.	GENERAL PROVISIONS.....	5

APPENDIX:

ELECTRONIC FUNDS TRANSFER FORM SIGNATURE
PAGE

Oklahoma Department of Corrections

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 Correction'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 57 O.S. 1980, § 505 et seq., as amended, to administer and manage the incarceration of persons who have committed felony crimes or are otherwise subjected to criminal sanctions within the State of Oklahoma.
- 1.2 The Dentist is duly licensed by the state of practice as a practitioner of 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 for the benefit of the inmates under its care, custody, and control.
- 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 medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.
- 2.4 "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.

- 2.5 "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 inmate, the inmate'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.
- 2.6 "Dental Services" means the professional services provided by a Network Dentist and covered by the Department.
- 2.7 "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 inmates.
- 2.8 "Pre-estimation" means the itemization of proposed dental services and the expected charges prior to treatment.
- 2.9 "Third Party Payer" 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 inmates under the care, custody and control of the Department. 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 an inmate. The Dentist reserves the right to refuse to furnish services to an inmate 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, an inmate 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 inmates that are deemed appropriate, and covered by the Department.
- 4.3 The Dentist agrees to make reasonable effort to refer covered inmates 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 the Department's inmates medications identified on the adopted formulary or explain, in writing, on behalf of the inmate to the Department why it is inappropriate to do so.
- 4.5 The Dentist shall submit a current, complete and accurate Oklahoma Uniform Credentialing Application (ODH Form 606) and EGID OUCA Supplement as allowed under OK §63-1-106.2 and Laws 1998, c. 210, § 1 which are incorporated herein by reference. 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'S 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 continue listing the Dentist as a Network Provider until this Contract terminates.
- 5.3 The Department agrees to provide the Dentist access to a listing of all Network Providers.
- 5.4 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.
- 5.5 The Department shall give a 48 hour notice prior to an audit.
- 5.6 The Department shall maintain a pre-estimation program in order to aid in making decisions that will maximize dental benefits and reduce 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 shall have the right to categorize what shall constitute a procedure. The Department'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.

- b) The Dentist agrees not to charge more for dental services to inmates than the amount normally charged by the Dentist to other patients for similar services. The Dentist may, however, contract with other third party payers for services. The Dentist's usual and customary charges may be requested by the Department and verified through an audit.
- 6.3 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 Dentist is seeking reimbursement through the Department.
- 6.4 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.
- 6.5 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 inmates at no cost to the Department or the inmate.

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 have the right to use the name, office address, telephone number and specialty of the Dentist for purposes of informing Department liaisons at each inmate facility of the identity of the Network Providers.
- 8.2 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 inmates 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. The Network Newsletter serves as the primary method by which providers receive all other notifications mandated by the terms of the provider contracts. These notices from EGID may be sent via electronic newsletters distributed electronically to each Network Provider's correspondence email address. Printed newsletters are sent via the postal service to the mailing address on record for providers without internet access or those who have undeliverable email addresses.
- 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 inmates. 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.
- 11.8 All Providers certify that neither they nor their principals are presently debarred or suspended or otherwise ineligible according to the Excluded Parties List System (EPLS)/Office of Inspector General (OIG) excluded provider lists.
- 11.9 As mandated by HB1086, the Transparency, Accountability, and Innovation in Oklahoma State Government 2.0 Act of 2011, all payments disbursed by the Office of the State Treasurer must be made solely through electronic funds transfer (EFT). Provider/facility hereby agrees to accept EFT payments by July 1, 2013. Provider acknowledges that all health and dental claims received after July 1, 2013, regardless of the date of service, will be denied pending receipt of additional information if EFT payment information is not on file as of July 1, 2013.

Electronic Funds Transfer (EFT) Authorization Agreement

Provider Information

Provider Name: _____
Doing Business As Name (DBA): _____

Provider Address

Street: _____
City: _____ State/Province: _____ ZIP Code/Postal Code: _____

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or
Employer Identification Number (EIN): _____
National Provider Identifier (NPI): _____ Provider Type: _____

Financial Institution Information

A VOIDED CHECK OR A BANK LETTER VERIFYING THE ACCOUNT AND ROUTING NUMBERS IS REQUIRED.

Financial Institution Name: _____
Financial Institution Routing Number: _____
Type of Account at Financial Institution: _____
Provider's Account Number with Financial Institution: _____
Account Number Linkage to Provider Identifier: _____
 Provider Tax Identification Number (TIN) or National Provider Identifier (NPI)

You must contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA. Online instructions on how you can determine the status of your EFT enrollment is available at <http://www.ok.gov/sib/Providers/EFT/index.html>

Submission Information

Reason for Submission
 New Enrollment Change Enrollment

Authorized Signature

I hereby authorize the Employees Group Insurance Department (EGID) to initiate credit entries in accordance with HB 1086 Transparency, Accountability and Innovation in Oklahoma State Government 2.0 Act of 2011 to the account indicated above. I hereby authorize the financial institution/bank named above to credit the same to such account.

Written Signature of Person Submitting Enrollment: _____
Printed Name of Person Submitting Enrollment: _____
Printed Title of Person Submitting Enrollment: _____
Submission Date: _____

EFT INSTRUCTIONS

Please complete this EFT form in its entirety. Leaving required fields blank or failing to attach a voided check or bank letter will result in an incomplete application and/or denied claims. If you have any questions regarding the use of this form or any of the information requirements, please contact us using the information listed at the bottom of page 1 of this form. To ensure the security of your information when submitting this form via email, please submit your form and any attachments in an encrypted WinZip file, then submit the password for the WinZip file in a separate email.

THE EFT FORM IS A **MANDATORY** PART OF YOUR ENROLLMENT APPLICATION

Provider Information

Provider Name	Complete legal name of institution, corporate entity, practice or individual provider	Required
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it	Optional

Provider Address

Street	The number and street name where a person or organization can be found	Required
City	City associated with provider address field	Required
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country	Required
ZIP Code/Postal Code	System of postal-zone codes (ZIP stands for zone improvement plan) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities	Required

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity	Required
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions	Required (when provider has been enumerated with an NPI)
Provider Type	A proprietary health plan-specific indication of the type of provider being enrolled for EFT with specific provider type description included by the health plan in its instruction and guidance for EFT enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)	Optional

Financial Institution Information

Financial Institution Name	Official name of the provider's financial institution	Required
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited	Required
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving	Required
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited	Required
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice	Required

Submission Information

Reason For Submission	Check appropriate box. Please note that EFT cannot be cancelled.	Optional
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Authorized Signature

Written Signature of Person Submitting Enrollment	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment	Required
Printed Name of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity	Optional
Printed Title of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
Submission Date	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
	The date on which the enrollment is submitted	Optional

State of Oklahoma
Department of Corrections
Dental Contract
Signature Page

When signed by both parties below, this constitutes agreement and acceptance of all terms and conditions contained in the Dental 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:

FOR DOC:

Name (Typed or Printed)

Director or Chief Medical Officer
Department of Corrections
3400 Martin Luther King Avenue
Oklahoma City, OK 73111

Signature

NPI

Federal Tax ID Number

Primary Service Address:

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

Oklahoma Department of Corrections
ATTN: Network Management
P.O. Box 57630
Oklahoma City, OK 73157-7630
Phone: 1-405-717-8750 or 1-866-573-8462
Fax: 1-405-717-8977

Electronic Remittance Advice (ERA) Authorization Agreement

Provider Information

Provider Name: _____

Doing Business As Name (DBA): _____

Provider Address

Street: _____

City: _____ State/Province: _____ ZIP Code/Postal Code: _____

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): _____

National Provider Identifier (NPI) _____ Provider Type: _____

Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)

Provider Tax Identification Number (TIN): _____

National Provider Identifier (NPI): _____

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name: _____

Clearinghouse Contact Name: _____ Telephone Number: _____

Submission Information

Reason for Submission

New Enrollment

Change Enrollment

Cancel Enrollment

Authorized Signature

I hereby authorize the Office of Management and Enterprise Services Employees Group Insurance Department to send electronic remittance advice (ERA/835) as designated herein. I am authorized to elect Electronic Remittance Advice (ERA) transactions on behalf of the indicated party and I acknowledge the same by signing below.

Written Signature of Person Submitting Enrollment: _____

Printed Name of Person Submitting Enrollment: _____

Printed Title of Person Submitting Enrollment: _____

Submission Date: _____

Please mail, fax or email the completed form or questions to:
Office of Management and Enterprise Services Employees Group Insurance Department
3545 N.W. 58th St, Ste., 110, Oklahoma City, OK 73112
Phone: 405-717-8790 or 800-543-6044 or Fax: 405-717-8977 or 405-717-8702
EGID.EFTEnroll@omes.ok.gov or EGID.NetworkManagement@omes.ok.gov

ERA INSTRUCTIONS

Please complete this ERA Form in its entirety. Leaving any required fields blank will result in an incomplete process. If you have any questions regarding the use of this form, or any of the field requirements, please see our contact information listed at the bottom of page 1 of this form. Information about how to check the status of your ERA is available at www.ok.gov/sib/Providers/Provider_EFT/index.html

Provider Information

Provider Name	Complete legal name of institution, corporate entity, practice or individual provider	Required
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it	Optional

Provider Address

Street	The number and street name where a person or organization can be found	Required
City	City associated with provider address field	Required
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable country	Required
ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities	Required

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity	Required
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions	Required (when provider has been enumerated with an NPI)
Provider Type	A proprietary health plan-specific indication of the type of provider being enrolled for ERA with specific provider type description included by the health plan in its instruction and guidance for ERA enrollment (e.g., hospital, laboratory, physician, pharmacy, pharmacist, etc.)	Optional

Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)	Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment	Required
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Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name	Official name of the provider's clearinghouse	Required; i.e., Emdeon This should be the clearinghouse who is currently handling your electronic claims for HealthChoice, Oklahoma Department of Corrections and/or Oklahoma Department of Rehabilitation Services Any request for routing of ERAs to another destination will require additional setup and testing.
Clearinghouse Contact Name	Name of a contact in clearinghouse office for handling ERA issues	Optional
Telephone Number	Telephone number of contact	Optional

Submission Information

Reason For Submission	Check appropriate box.	Required
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Authorized Signature

The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment

Required

Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity	Optional
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment	Optional
Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment	
Submission Date	The date on which the enrollment is submitted	Optional