Cypress ANCILLARY BENEFITS
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Provider Contact and Information Packet

PROVIDER CHECK LIST

Easy to Enroll:

1. Complete the enclosed paperwork
2. Review the Checklist of Items needed
3. Submit via fax or email:
   - Fax: 209-478-5614 (Attn: Provider Services)
   - Email: providerservices@cypressadmin.com

Original

- ☐ Signed Dentist Agreement (We need the doctor to sign and return the back page)
- ☐ Practice and Facility Form (One per office)
- ☐ Provider Application (One per doctor, make copies if needed)
- ☐ Signed Provider Fee Schedule (We need final page signed by all providers and returned)
- ☐ Completed W9 form

Copies of your (and your Associates')

- ☐ Wallet-size Dental License
- ☐ DEA License
- ☐ Malpractice Insurance declarations page

www.cypressadmin.com

Cypress ANCILLARY BENEFITS
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Cypress Ancillary Benefits
7510 Shoreline Drive, Ste A-1, Stockton, CA 95219
p: 800-350-3989 • f: 209-478-5614
email: providerservices@cypressadmin.com
www.CypressAdmin.com

PRACTICE & FACILITY FORM

PRACTICE INFORMATION

Practice Name | Phone | Fax

Address | City | State | Zip Code

Mailing Address (if different from above) | City | State | Zip Code

Billing Provider NPI | Tax ID Number (TIN) or Employer ID Number (EIN)

Email | Legal Entity *(check one)* ☐ Corporation ☐ Partnership ☐ Sole Proprietor

Office Staff | Dentists: | Hygienists: | Assistants: | Receptionists: | Operatories:

Foreign Languages Spoken: ☐ Cantonese ☐ Chinese ☐ Farsi ☐ Hmong ☐ Korean ☐ Mandarin ☐ Punjabi ☐ Russian ☐ Spanish ☐ Vietnamese ☐ Other _____

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

FACILITY DETAIL

Facility Location (check one): ☐ Professional Building ☐ Stand-alone Building ☐ Shopping Center

Number of Accessible Parking Spaces: _____ Handicap Accessible? ☐ NO ☐ YES Near Public Transit? ☐ NO ☐ YES

Waiting Room Capacity: _____ Drinking Fountain? ☐ NO ☐ YES Patient Education Materials Available? ☐ NO ☐ YES

Number of Operatories: _____ Expansion Capability? ☐ NO ☐ YES Credit Cards Accepted? ☐ NO ☐ YES

Number of Standard X-Ray Machines: _____ Panorex? ☐ NO ☐ YES Digital X-Ray? ☐ NO ☐ YES

Laboratory Capacities (check all that apply): ☐ Pouring Models ☐ Minor Repairs ☐ Fabricate Dentures ☐ Fabricate Crowns

Facility uses computer(s) for (check all that apply): ☐ Practice Management ☐ Appointment Scheduling ☐ Insurance Billing (EDI) ☐ Accounts Receivable ☐ Computers not used

CAPACITY / AVILABILITY

Total Maximum Capacity (number of patients): At what percentage of your Total Maximum Capacity are you operating?

Access/Appointment Availability: Initial: _____(wks) Routine: _____(wks) Hygiene: _____(wks) Emergency: _____(hrs)

Average Waiting Time in Office with Appointment:

AFTER-HOURS ACCESS

Does your office have an answering service or answering machine during non-business hours which provides instructions regarding how patients may obtain urgent or emergency care? ☐ NO ☐ YES

PROVIDER APPLICATION

(Duplicate for additional providers)

Cypress Ancillary Benefits
7510 Shoreline Drive, Ste A-1, Stockton, CA 95219
p: 800-350-3989 • f: 209-478-5614
email: providerservices@cypressadmin.com
www.CypressAdmin.com

Billing Tax ID | Practice Name

Practice Address | Telephone Number

Title ☐ D.D.S. ☐ D.M.D. Specialty: ☐ Endodontist ☐ Oral Surgeon ☐ Orthodontist ☐ Pedodontist ☐ Periodontist ☐ Prosthodontist

Last Name | First Name | Middle Initial | Gender ☐ Male ☐ Female

Date of Birth | Social Security # | License # | Rendering Provider NPI

Do you prescribe medications? ☐ NO ☐ YES | Dental School Name | Year Graduated

DEA # _____

SPECIALTY BOARD STATUS Are you Board Certified? ☐ NO ☐ YES If No, are you or have you been Board Eligible? ☐ NO ☐ YES

If Yes, Year of Board Certification_____ Expiration _____

PROFESSIONAL WORK HISTORY

Please list all present and previous dental work history within the past five (5) years. Please provide written explanation of any breaks in history greater than 6 months. Curriculum vitae accepted in lieu of completing the following table.

Hire Date (mm/yy)	Term Date (mm/yy)	Employer	Location Address	Reason for Leaving

PROFESSIONAL LIABILITY INSURANCE *(Required coverage minimum: $500,000 per incident, $1,000,000 aggregate)*

Carrier | Limits | Effective Date | Term Date

HOSPITAL ADMITTING PRIVILEGES: Do you have hospital privileges? ☐ NO ☐ YES *(please complete below)*

Hospital Name | Address | Phone

CONFIDENTIAL INFORMATION

For any "Yes" response in this section, please provide a brief explanatory statement with your completed form.

1. Within the past five years up to and including the present, have you been involved in any malpractice suit or arbitration, or has any settlement ever been paid by you or paid on your behalf? IF YES, please provide a narrative and status for each case. ☐ YES ☐ NO

2. Have you ever had any one of the following items denied, revoked, suspended, not renewed, placed on probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items:
   - State license ☐ YES ☐ NO
   - DEA, CDS, or other applicable narcotic registration ☐ YES ☐ NO
   - Hospital or other health-care facility staff membership or privileges ☐ YES ☐ NO
   - Medicaid or other government program participation ☐ YES ☐ NO
   - HMO, PPO, or other managed care plan ☐ YES ☐ NO
   - Employment as a health-care provider by a military service, hospital, HMO, or other health-care organization ☐ YES ☐ NO

3. Do you have any condition that, with or without accommodation, would make you unable to perform the essential functions within your area of practice or unable to perform such essential functions without health and safety of patients? ☐ YES ☐ NO

4. Within the past five years up to and including the present, have you used illegal drugs or have you had a chemical dependency or substance abuse problem? ☐ YES ☐ NO

5. Have you ever been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime? ☐ YES ☐ NO

Please attach legible COPIES of the following:

State Dental License (wallet-size only)
DEA Certificate (if applicable)
Specialty Board Certificate (if applicable)
General Anesthesia License (if applicable)

ATTESTATION

I, the undersigned, hereby certify that the information provided on this application is truthful, correct and complete in all respects, and I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating dentist with the dental plan. The undersigned hereby agrees to notify the dental plan of any changes in the above information.

_____ Dentist's Signature *(no signature stamps)*

_____ Date

Cypress ANCILLARY BENEFITS
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Dentist Agreement

Please Return Back Page Signed by Dentist

THIS AGREEMENT is made and entered into by and between Cypress Ancillary Benefits, a California Corporation ("Cypress") and the undersigned Dentist, licensed to practice dentistry in the state noted on the signature page ("DENTIST").

WHEREAS, Cypress has developed a participating provider organization ("PPO") to provide professional dental services through individual and group contracts ("DENTAL PLANS") with employee groups, unions, corporations, insurance companies, dental claim administrators, government agencies and other payors ("Payors") and to make such dental services available to eligible employees or members of such groups and their covered dependents ("Covered Individuals"), and

WHEREAS, Cypress agrees to make available to Covered Individuals the name, address and telephone number of DENTIST, and

WHEREAS, DENTIST is willing to provide the Dental Services under the terms and conditions set forth below.

NOW, THEREFORE, in consideration of the promises and mutual covenants contained in this Agreement and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is mutually covenanted and agreed as follows:

1. **DENTAL SERVICES:** Dentist agrees to render dental services ("Dental Service") to Covered Individuals, all in accord with Cypress's policies, as specified in Cypress's Dentist Handbook. Dentist agrees not to discriminate or differentiate in the treatment of Covered Individuals based on color,creed, age, sex, marital status, religion, or otherwise.
2. **FEES: DENTIST** agrees to charge Covered Individuals no more than the amounts set forth in the attached Exhibit A (fee schedule) as payment in fullfor services rendered under the scope of the AGREEMENT. Further, DENTIST agrees that any services not listed in the Maximum Fee Schedule be provided at the DENTIST's Usual and Customary Rate (UCR) for such dental services. The fee schedule in Exhibit A will apply even if the applicable Dental Plan is secondary for purposes of coordination of benefits.
3. **BILLING:** Billing shall include detailed and descriptive dental and patient data and identifying information on forms approved by Cypress and DENTIST agrees to adhere to billing guidelines as specified in Cypress's Dentist Handbook. DENTIST shall look solely to the applicable Payor for such compensation and shall not seek compensation from Covered Individuals, except for applicable co-payments, deductibles or services not covered under the applicable Dental Plan. DENTIST understands that presentation of a Cypress Identification Card by any person is not a guarantee that the person is a Covered Individual and entitled to benefits on the date of service. DENTIST understands that payments for services are made for Covered Individuals who are eligible on the date of service, as determined by Cypress's eligibility department.
4. **ELECTRONIC TRANSFER OF FUNDS AND PAYMENT / BENEFIT DATA:** In 2009, Cypress intends to implement an electronic payment process whereby it will pay dental claims electronically by transferring funds to DENTIST'S designated bank account. Therefore, once implemented, DENTIST agrees to receive claim payments electronically from Cypress in such bank account as DENTIST specifically designates in writing. Once the electronic transfer of funds payment process is implemented, DENTIST also agrees to receive his or her patient's explanation of benefits and any other communication from Cypress by facsimile or other electronic means available to DENTIST. If, however, DENTIST elects to receive claim payments and various patient communications by mail, DENTIST shall notify Cypress in writing. Other Payors that utilize Cypress's dental network may continue to utilize or request that claim payments and other information be transmitted solely by mail. If requested by a Payor, DENTIST agrees to continue to receive claim payments and patient information from those Payors through the mail.
5. **PROVIDER DISPUTE RESOLUTION MECHANISM:** If any dispute arises between Cypress and DENTIST, the party challenging, appealing, or requesting reconsideration of a decision or a billing determination or other contract dispute shall provide written notice to the other party. The notice shall specify the basis for the dispute.
6. **COMPLAINTS:** DENTIST agrees to cooperate with and provide Cypress with all information necessary to resolve Covered Individual's grievances with respect to Dental Services.
7. **QUALITY ASSESMENT/UTILIZATION REVIEW:** DENTIST agrees to participate in and adhere to the quality assessment and utilization review programs of Cypress. DENTIST further agrees that payments will be made by applicable Payor only for Dental Services rendered in accordance with the quality Assessment/Utilization Review Program.
8. **LIABILITY FOR TREATMENT OR SERVICE:** DENTIST solely shall be responsible to Covered Individuals for treatment or service. Nothing in this Agreement is intended to create, nor shall it be construed to create, any rights to Cypress to intervene in any manner with, nor shall it render them responsible for, the method or means by which DENTIST renders treatment or service to Covered Individuals.
9. **DENTIST'S LICENSURE, INSURANCE AND INDEMNIFICATION:** DENTIST shall, at his/her sole expense, meet and continue to meet, all applicable regulations relating to professional licensing, including without limitation, continuing dental education requirements. This agreement shall terminate immediately if DENTIST's license to practice dentistry is suspended, revoked or nullified in any state in which he/she practices. DENTIST, at his/her sole cost and expense, shall procure and maintain such policies of general and professional liability and other insurance as necessary to insure DENTIST and DENTIST's employees against any claim for damages arising by reason of personal injuries or death occasioned directly or indirectly by the performance of Dental Service by DENTIST. Memorandum copies of such policies shall be delivered to Cypress upon request. The insurance coverage will be in effect prior to the effective date of the Agreement. DENTIST will give Cypress thirty (30) days advance written notice of the termination of such policies. Termination of such policies will cause this Agreement to immediately terminate. The coverage amount of insurance shall be no less than Five Hundred Thousand Dollars ($500,000) per incident or occurrence and One Million Dollars ($1,000,000) in aggregate coverage. DENTIST shall indemnify, protect, defend and hold Cypress and all payors, and their officers, shareholder, directors, employees and agents harmless for, from and against any and all claims, demands, liabilities, losses, damages, judgments, costs, taxes and expenses sustained or incurred by any one in connection with any action or omission of DENTIST.

Cypress ANCILLARY BENEFITS
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Dentist Agreement

10. **ROSTER:** DENTIST agrees that Cypress may use DENTIST'S name, address, telephone number, and descriptions of care and specialty services in any roster of participating Dentist. Upon termination of this agreement, Cypress will remove DENTIST'S information from future published directories.
11. **MEMBER COPAYMENTS AND DEDUCTIBLE:** DENTIST agrees not to waive any Covered Individuals copayments or deductible. DENTIST acknowledges that waiving Covered Individuals copayments and deductible does cause substantial financial harm to Cypress and Cypress has the right to recoup losses from DENTIST.
12. **INSPECTION OF RECORDS:** DENTIST and Cypress agree that all Covered Individual records will be available for review by Cypress during business hours upon prior notification by Cypress to the DENTIST. It is further agreed that all records will be treated as confidential so as to comply with all state and federal laws regarding their confidentiality.
13. **COMPLIANCE WITH LAW:** DENTIST shall conduct his/her/its professional practice and supervise all personnel in a manner that complies with all applicable laws, and shall maintain all necessary permits, certificates and licenses in good standing. DENTIST shall promptly notify Cypress of any complaints and any disciplinary actions taken based upon DENTIST'S practices or the practices of any other partner or shareholder of DENTIST. DENTIST hereby authorizes any government agency regulating or supervising the practice of dentistry to release to Cypress information relating to any such complaints or disciplinary actions.
14. **TERM OF AGREEMENT, TERMINATION:** The initial term of this Agreement shall end one year from the date the contract was signed. The Agreement will automatically renew for subsequent 12 month periods unless terminated by Cypress or DENTIST. Either party may terminate this agreement for any reason or no reason without cause by giving written notice to the other party at least 60 days prior to the date of termination. In the event this Agreement is terminated, DENTIST will provide Dental Services under the terms of this Agreement as if it had not terminated for any dental condition for which treatment has begun as of the termination date until all necessary Dental Services for each condition have been completed.
15. **ARBITRATION:** All disputes, controversies, or claims arising out of or relating to the interpretation of this Agreement shall be settled by final and binding arbitration in accordance with the Commercial Arbitration Association, to the extent such rules are not inconsistent with this Agreement. Any award rendered by the arbitrators shall be final and binding upon the parties hereto, and judgment upon any such award may be entered in any court having jurisdiction thereof. The fees and expenses of the arbitrators shall be borne equally by the parties. Each party shall pay its own fees and costs relating to any arbitral proceedings, including attorney's fees.
16. **HEADINGS:** The headings of paragraphs contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.
17. **WAIVER OF BREACH:** Waiver of a breach of this Agreement shall not be deemed to be a waiver of any other breach or of the same breach at a later time.
18. **ASSIGNMENT:** DENTIST may not assign or transfer any of his/her rights or obligations hereunder, without the prior written consent of Cypress.
19. **RELATIONSHIP OF THE PARTIES:** The relationship between DENTIST and Cypress shall be that of two independent entities contracting with each other at arm's length. Neither party shall be deemed the agent of the other and no joint venture or partnership shall result from this Agreement.
20. **NOTICE:** Any and all notices required to be given pursuant to the terms of this Agreement must be given by United States mail, postage prepaid return receipt requested, and forwarded to the following address or other such as either party may in writing submit.

If to CYPRESS
Provider Relations Coordinator
Cypress Ancillary Benefits
7510 Shoreline Drive Suite A-1
Stockton, CA 95219

If to DENTIST
Name

Address

IN WITNESS WHEREOF, the parties have executed and entered into this Agreement as of the day and year set forth on this page.

Cypress Ancillary Benefits
by:

Title: Vice President, Plan Administration

Date:

DENTIST
by: _____
(Dentist Signature)
Print Name: _____
Tel. Number (include area code):
Date: License #:

Please Sign and Return this page

PROVIDER DISPUTE RESOLUTION MECHANISM

Dear Provider:

Enclosed, please find a Contract Amendment regarding Cypress Ancillary Benefits ("Cypress") Provider Dispute Resolution Mechanism. The details of the Dispute Resolution process are provided below for your reference. Please sign the enclosed Amendment and return it to the address listed below. A copy of the Amendment will be returned to you after it is signed by Cypress.

Address: Cypress Ancillary Benefits
Attn: Provider Relations Department
7510 Shoreline Drive, Ste A-1
Stockton, CA 95219

Phone: 800.350.3989

Thank you for your attention to this matter.

Cypress Ancillary Benefits
Provider Relations Department

Definition of a Provider Dispute:

A provider dispute (for contracted and non-contracted providers) is a provider's written notice to Cypress Ancillary Benefits *("**Cypress**")* challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted or contested or seeking resolution of a billing determination or a contract dispute or disputing a request for reimbursement of an overpayment of a claim.

Each provider dispute must contain, at a minimum, the following information:

- Provider's Name, Provider's License Number, Provider's Contact Information, **and**:

    1. If the provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from ***Cypress*** to a provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect; or
    2. If the provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue.

Provider disputes submitted by the provider on behalf of an enrollee will be resolved through ***Cypress's*** Consumer Grievance Process and not through ***Cypress's*** Dispute Resolution Mechanism.

Sending a Provider Dispute to *Cypress*:

Provider disputes submitted to ***Cypress*** must include the information listed above, for each provider dispute. All provider disputes must be sent to the attention of the Provider Dispute Resolution Department at the following:

Via Mail: Cypress Ancillary Benefits
ATTN: Provider Dispute Resolution Department
7510 Shoreline Drive, Ste A-1
Stockton, CA 95219

Phone: 800.350.3989

Time Period for Submission of Provider Disputes:

Provider disputes must be received by ***Cypress*** within 365 days from ***Cypress's*** action that led to the dispute.

Provider disputes that do not include all required information as set forth above may be returned to the submitter for completion. An amended provider dispute which includes the missing information may be submitted to ***Cypress*** within thirty (30) working days of your receipt of a returned provider dispute.

Acknowledgment of Provider Disputes:

Cypress will acknowledge receipt of all provider disputes within fifteen (15) working days of the date of receipt by ***Cypress*** and will issue a written determination within forty-five (45) working days after the receipt of the provider dispute.

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

Request for Taxpayer Identification Number and Certification

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

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

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

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

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

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

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

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

☐ Other (see instructions) ▸

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

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

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

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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

By signing the filled-out form, you:

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