Participating Provider Contract

www.cseaebf.com 800-323-2732
PO Box 489 Latham NY 12110

The undersigned hereby applies to the CSEA Employee Benefit Fund ("Fund") to be included on the Fund's panel of Dental Providers.

I have reviewed the fee schedules for the Sunrise, Horizon, Equinox, Dutchess, State, Retiree, EBF Member Plus, and Unified Court System dental plans and if my application is accepted by the Fund, I agree to accept the listed fees as payment in full with respect to all plans except the *UCS Retiree plan*, whether payments are made by the Fund, the covered employees or their dependents, and to accept assignment of benefits from covered employees without recourse as against the covered employees or their dependents. I acknowledge that the plans have different fee schedules. Treatments excluded by the applicable plan, as well as costs, will be discussed with the CSEA members prior to commencing any treatment. All licensed individuals whether employees, partners, associates or independent contractors who perform services at my facility are obligated to accept the fee schedule as payment in full. I also acknowledge that if the Fund, the covered employees or their dependent(s) make a payment to me to which I am not entitled and which I do not return upon written request, the Fund has the right to offset that payment against other payments to which I am entitled. I further acknowledge that the Fund or its representative has the right to audit my records to confirm my compliance with the requirements for being included on the Fund's panel of Dental Providers.

I acknowledge that the Fund accepts both electronic claims and paper claims. If electronic claims are used, I will submit to Change Healthcare, Tesia, or DentalXchange clearinghouse. If claims are submitted using a paper format, I will submit claims using the universal American Dental Association (ADA) Dental Claim Form. "Signature on File" is acceptable for processing claims submitted. I agree to maintain "Signature on File" in my records and provide to the Fund upon request.

Please include me in your directory at the office(s) listed. I understand that the Fund has the right to decline to include me (or any of my locations) on the Fund's panel and to terminate my participation at any time at its sole discretion. If the Fund accepts my application, the terms set forth above will remain in effect until the Fund terminates my participation or until 30 days after the Fund receives written notice that I am terminating my participation. Once I give or receive written notice of termination, I must not begin any new treatment, must finish treatment that has been started and cannot leave any temporary or incomplete treatment.

You must notify the FUND regarding changes that apply to this contract such as an address change, addition or closing of an office, change in TIN or change in ownership or employees.

Dentist's Full Name (please print) *Dentist's Signature*

License Number *NPI*

Office/Billing Entity name (Associated with Taxpayer ID)

Taxpayer ID *Date*

TO BE LISTED AS A SPECIALIST, A COPY OF YOUR SPECIALTY CERTIFICATION MUST BE INCLUDED.

ADA approved specialist? ***(Circle One)*** *Yes No* ***(Circle Speciality Type)*** *Endodontics Periodontics Prosthodontics*

Are you Board certified in your specialty? ***(Circle One)*** *Yes No* *Oral Surgery Orthodontics Pediatric Dentistry*

OFFICE LOCATIONS: PLEASE PROVIDE THE ADDRESS AND PHONE NUMBER WITH AREA CODE IN THE SPACES BELOW.

Street City State Zip County Phone

Street City State Zip County Phone

Street City State Zip County Phone

E-mail address *Website*