G.E.H.A | Connection Dental Network

Connection Dental Network – Provider Application

Please fill out as shown on provider license.

URAC ACCREDITED Dental Network Expires 08/01/2025

connectiondental.com

Your application cannot be processed without the following:

Completed, signed, and dated application, including:

- ☐ Last five years of dental work history, with explanations of any gaps of 180 days or more
- ☐ New graduates with less than five years' work history must account for gaps of 180 days or greater between licenser date and work history start date
- ☐ Completion dates for all dental training and education

Completed, signed and dated professional questions and attestation within 120 days prior to submission

- ☐ Include any required written explanations, if applicable

Completed, signed, and dated Participating Provider Agreement

- ☐ 1st page of fee schedule that applicant received from GEHA Connection Dental Network – if not submitted fee schedule will be assigned by GEHA Connection Dental Network

Copy of current, professional malpractice insurance declaration page

Additional items that may be requested:

- ☐ Copy of DEA, sedation and anesthesia licenses and/or a wavier for all states in which you practice. Please include a copy of all active dental licenses.
- ☐ Copy of diploma if foreign educated or trained

Additional location forms can be found at connectiondental.com

General information PLEASE COMPLETE EACH SECTION IN BLACK INK. IF A QUESTION IS NOT APPLICABLE, WRITE "N/A." ALL SECTIONS MUST BE COMPLETED

Last name:	First name:	MI:	Suffix:
Other names are known by:		Degrees: DDS ☐ DMD ☐ BDS ☐ MD ☐ Other ☐	
Social Security Number:	Male ☐ Female ☐	Date of birth:	
NPI 1 (Individual):	Race:	Ethnicity:	
Languages other than English spoken by dentist:			

G.E.H.A / Connection Dental Network follows the NCQA guidelines and as such organizations must comply with all applicable federal and state civil rights laws that prohibit discrimination on the basis of race, color, national origin, age, disability, sex, or language. Connection Dental Network makes decisions in a nondiscriminatory manner. Providing race, ethnicity or language information is optional.

Please fill out as shown on provider license.

License and identification numbers PLEASE LIST ALL STATE LICENSES YOU HAVE HELD, CURRENT DEA and SDC *IF NONE, CONSIDERED WAIVED*

License and identification numbers (attach additional pages if necessary)

State	License number	License status		Federal DEA number	DEA Exp (MM/YY)			State Drug Certificate number	SDC status		
		Active	Inactive		Active - Exp Date MM/YY	In Process MM/YY	*No DEA		Active	Inactive	N/A

- You must have at least one active state license to apply to join this network.
- Complete one line for each state license you currently have or have ever held.

PLEASE INCLUDE ALL OF YOUR CURRENT AND PREVIOUS STATE LICENSES ON THIS TABLE AND ATTACH A PAGE, IF NEEDED.

- Must include a federal DEA registration number with current status - OR - select 'No DEA' for each active state license listed on this table.
- Select 'In Process', If in the process of applying or updating the address for your DEA registration.
- *By selecting 'No DEA'* - I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management.

- If you are required to have a state Drug Certificate in order to prescribe or dispense medications in your state, complete this section for each Active state license listed on this table.

YOU MAY CALL OUR CREDENTIALING DEPARTMENT AT (800) 505-8880, EXT 4046, WITH QUESTIONS ABOUT SDCREQUIREMENTS IN YOUR STATE.

Person completing application (if different than provider)	First name:	Last name:
Contact email:		Phone:

Dental specialty IF OTHER THAN GENERAL DENTISTRY

Are you a specialist? Yes ☐ No ☐	If yes, list specialty:	List subspecialty:

American Board Certification THIS IS SEPARATE FROM THE STATE DENTAL BOARD LICENSE/CERTIFICATION

Are you American Board Certified: Yes ☐ No ☐	Date certified:	Valid until:

Please select the type of American Board Certification below:

ABOMS ☐ ABOMP ☐ ABPD ☐ ABE ☐ ABO ☐ ABDPH ☐ ABMS ☐ ABOP ☐ ABOI ☐ ABOMR ☐ ABGD ☐

ABPerio ☐ ABProstho ☐ ABCD ☐ ABDSM ☐ ABDA ☐ None ☐

Professional education IF FOREIGN TRAINED, MUST INCLUDE A COPY OF YOUR DIPLOMA

Name of school:		State:	Country:
Degree:	Graduation date:	Phone:	

Professional training – internship/residency/fellowship IF APPLICABLE

Training institute 1:	Start date:	City:	State:
Phone:	Date completed:	Type of training/specialty:	
Program: Internship ☐ Residency ☐ Fellowship ☐		Was the program successfully completed? Yes ☐ No ☐	
Training institute 2:	Start date:	City:	State:
Phone:	Date completed:	Type of training/specialty:	
Program: Internship ☐ Residency ☐ Fellowship ☐		Was the program successfully completed? Yes ☐ No ☐	
Training institute 3:	Start date:	City:	State:
Phone:	Date completed:	Type of training/specialty:	
Program: Internship ☐ Residency ☐ Fellowship ☐		Was the program successfully completed? Yes ☐ No ☐	

Hospital affiliations IF APPLICABLE. ATTACH ADDITIONAL PAGES IF NEEDED

Do you have hospital affiliations? Yes ☐ No ☐	Hospital name:	
City:	State:	Phone:

Professional liability claims history PLEASE INCLUDE THE LAST 5 YEARS OF ALL PROFESSIONAL LIABILITY CASES

Number of cases settled:	Number of cases that resulted in adverse judgment against dentist:

Five-year dental employment history INCLUDE YOUR CURRENT PRACTICE LOCATION(S) AND ATTACH EXTRA PAGES*, IF NEEDED

Start date	End date	Employer name	City	State

**If you attach extra pages of Dental Employment history, be sure the information is up to date, and initial and date the pages before sending.*

If you have a gap of 180 days or greater between your initial state licensure date and your first dental employment date; -OR- if you have a gap in dental employment history of 180 days or greater during the last 5 years; you must include an explanation for each gap.

Gap start date	Gap end date	Reason for gap if 180 days or greater

**If you attach extra pages of Dental Employment history, be sure the information is up to date, and initial and date the pages before sending.*

If you acquired your initial state license within the last 5 years and have less than 5 years of dental employment history, complete this section.	Initial state of licensure:	Initial state licensure date:

Current practice and office information 1

Office name 1:		Start date:	Part time ☐ Full time ☐
Phone number:		Fax number:	
Physical address 1:	City:	State:	ZIP:
Location affiliated with dental group? Yes ☐ No ☐	Group name:	NPI 2 (organization):	
Location email:			
Office only email:			
What is the best way to reach you? Phone ☐ Email ☐ Fax ☐			
Tax ID name:		Tax ID:	
Is this location an Essential Community Provider? Yes ☐ No ☐		Indian Health Services location? Yes ☐ No ☐	

Complete these fields if different from physical address 1:

Billing or remit address			Mailing address	
Billing city	Billing state	Zip	Mailing city	
Billing phone	Billing fax	Pay to name	Mailing state	Zip

Office 1 services

Accepts new patients	Yes ☐ No ☐	Evening hours:	Yes ☐ No ☐
Medicare patients?	Yes ☐ No ☐	Include in Directory:	Yes ☐ No ☐
Medicaid patients?	Yes ☐ No ☐	Does this location offer Teledentistry:	Yes ☐ No ☐
Handicap access?	Yes ☐ No ☐	*If yes*, what platform is utilized?	
Are there any changes that affect your availability to patients?	Yes ☐ No ☐	What form of Teledentistry is performed? Asynchronous – Store & Forward Indirect Conference ☐ Synchronous – Live Audio/ Video Conference ☐	
Same day appointments?	Yes ☐ No ☐		
Difficult to schedule new patients?	Yes ☐ No ☐	Do you provide dental services via Mobile Dentistry	Yes ☐ No ☐
24/7 coverage?	Yes ☐ No ☐	If yes, what city & state does the Mobile Dentistry provide service in?	
Patient age limit?	Min age: Max age:	What services do you perform via the Mobile Dentistry?	
Weekend hours:	Yes ☐ No ☐	Diagnostic ☐ Preventative ☐ Restorative ☐ Other ☐	
Languages spoken by staff, other than English:		Where is the Mobile Dentistry service performed? Off-site patient/customer location ☐ Mobile Dentistry vehicle ☐	

Office Hours	Mon		Tues		Wed		Thurs		Fri		Sat		Sun	

Sedation/General Anesthesia credentialing requirements

1. Is sedation and/or general anesthesia administered in your practice location? (If no, do not complete the Sedation/Anesthesia Information.)	Yes ☐ No ☐
2. Do you administer sedation and/or general anesthesia? (If yes, please complete questions 3 through 6. If no, skip to question 5 and 6.)	Yes ☐ No ☐
3. Do you have current and valid state issued permits to administer anesthesia?	Yes ☐ No ☐

4. Please check and list all permits that you maintain and apply to your licensure in the state you are applying for:

Deep Sedation/General Anesthesia Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Moderate/Conscious sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Minimal sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Pediatric Moderate/Conscious Sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Nitrous Oxide Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Other permit type:	Permit/License #:
Expiration date:	State:

5. Do you have healthcare clinicians (DDS/DMD, MD, CRNA) providing sedation/anesthesia on patients you are treating at your practice locations?	Yes ☐ No ☐
6. Please confirm that you comply with and have verified that those providing sedation/general anesthesia on your patients comply with your state's requirements regarding equipment, supplies, and training, which includes arranging for and ensuring the presence of required personnel who will assist in administering sedation and general anesthesia in your office.	Yes ☐ No ☐

Credentialing contact information

Contact name:	Credentialing email:
Phone number:	Fax number:

Current practice and office information 2

Office name 2:		Start date:	Part time ☐ Full time ☐
Phone number:		Fax number:	
Physical address 2:	City:	State:	ZIP:
Location affiliated with dental group? Yes ☐ No ☐	Group name:	NPI 2 (organization):	
Location email:			
Office only email:			
What is the best way to reach you? Phone ☐ Email ☐ Fax ☐			
Tax ID name:		Tax ID:	
Is this location an Essential Community Provider? Yes ☐ No ☐		Indian Health Services location? Yes ☐ No ☐	

Complete these fields if different from physical address 2

Billing or remit address			Mailing address
Billing City, State, Zip			Mailing City, State, Zip
Billing phone	Billing fax		Pay to name

Office 2 services

Accepts new patients	Yes ☐ No ☐	Evening hours:	Yes ☐ No ☐
Medicare patients?	Yes ☐ No ☐	Include in Directory:	Yes ☐ No ☐
Medicaid patients?	Yes ☐ No ☐	Does this location offer Teledentistry:	Yes ☐ No ☐
Handicap access?	Yes ☐ No ☐	*If yes*, what platform is utilized?	
Are there any changes that affect your availability to patients?	Yes ☐ No ☐	What form of Teledentistry is performed? Asynchronous – Store & Forward Indirect Conference ☐ Synchronous – Live Audio/ Video Conference ☐	
Same day appointments?	Yes ☐ No ☐		
Difficult to schedule new patients?	Yes ☐ No ☐	Do you provide dental services via Mobile Dentistry	Yes ☐ No ☐
24/7 coverage?	Yes ☐ No ☐	If yes, what city & state does the Mobile Dentistry provide service in?	
Patient age limit?	Min age: Max age:	What services do you perform via the Mobile Dentistry?	
Weekend hours:	Yes ☐ No ☐	Diagnostic ☐ Preventative ☐ Restorative ☐ Other ☐	
Languages spoken by staff, other than English:		Where is the Mobile Dentistry service performed? Off-site patient/customer location ☐ Mobile Dentistry vehicle ☐	

Office Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Sedation/General Anesthesia credentialing requirements

1. Is sedation and/or general anesthesia administered in your practice location? (If no, do not complete the Sedation/Anesthesia Information.)	Yes ☐ No ☐
2. Do you administer sedation and/or general anesthesia? (If yes, please complete questions 3 through 6. If no, skip to question 5 and 6.)	Yes ☐ No ☐
3. Do you have current and valid state issued permits to administer anesthesia?	Yes ☐ No ☐

4. Please check and list all permits that you maintain and apply to your licensure in the state you are applying for:

Deep Sedation/General Anesthesia Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Moderate/Conscious sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Minimal sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Pediatric Moderate/Conscious Sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Nitrous Oxide Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Other permit type:	Permit/License #:
Expiration date:	State:

5. Do you have healthcare clinicians (DDS/DMD, MD, CRNA) providing sedation/anesthesia on patients you are treating at your practice locations?	Yes ☐ No ☐
6. Please confirm that you comply with and have verified that those providing sedation/general anesthesia on your patients comply with your state's requirements regarding equipment, supplies, and training, which includes arranging for and ensuring the presence of required personnel who will assist in administering sedation and general anesthesia in your office.	Yes ☐ No ☐

Credentialing contact information

Contact name:	Credentialing email:
Phone number:	Fax number:

Current practice and office information 3

Office name 3:		Start date:	Part time ☐ Full time ☐
Phone number:		Fax number:	
Physical address 3:	City:	State:	ZIP:
Location affiliated with dental group? Yes ☐ No ☐	Group name:	NPI 2 (organization):	
Location email:			
Office only email:			
What is the best way to reach you? Phone ☐ Email ☐ Fax ☐			
Tax ID name:		Tax ID:	
Is this location an Essential Community Provider? Yes ☐ No ☐		Indian Health Services location? Yes ☐ No ☐	

Complete these fields if different from physical address 3

Billing or remit address			Mailing address	
Billing city	Billing state	Zip	Mailing City	
Billing phone	Billing fax	Pay to name	Mailing State	Zip

Office 3 services

Accepts new patients	Yes ☐ No ☐	Evening hours:	Yes ☐ No ☐
Medicare patients?	Yes ☐ No ☐	Include in Directory:	Yes ☐ No ☐
Medicaid patients?	Yes ☐ No ☐	Does this location offer Teledentistry:	Yes ☐ No ☐
Handicap access?	Yes ☐ No ☐	*If yes*, what platform is utilized?	
Are there any changes that affect your availability to patients?	Yes ☐ No ☐	What form of Teledentistry is performed? Asynchronous – Store & Forward Indirect Conference ☐ Synchronous – Live Audio/ Video Conference ☐	
Same day appointments?	Yes ☐ No ☐		
Difficult to schedule new patients?	Yes ☐ No ☐	Do you provide dental services via Mobile Dentistry	Yes ☐ No ☐
24/7 coverage?	Yes ☐ No ☐	If yes, what city & state does the Mobile Dentistry provide service in?	
Patient age limit?	Min age: Max age:	What services do you perform via the Mobile Dentistry?	
Weekend hours:	Yes ☐ No ☐	Diagnostic ☐ Preventative ☐ Restorative ☐ Other ☐	
Languages spoken by staff, other than English:		Where is the Mobile Dentistry service performed? Off-site patient/customer location ☐ Mobile Dentistry vehicle ☐	

Office Hours	Mon		Tues		Wed		Thurs		Fri		Sat		Sun	

Sedation/General Anesthesia credentialing requirements

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2. Do you administer sedation and/or general anesthesia? (If yes, please complete questions 3 through 6. If no, skip to question 5 and 6.)	Yes ☐ No ☐
3. Do you have current and valid state issued permits to administer anesthesia?	Yes ☐ No ☐

4. Please check and list all permits that you maintain and apply to your licensure in the state you are applying for:

Deep Sedation/General Anesthesia Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Moderate/Conscious sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Minimal sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Pediatric Moderate/Conscious Sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Nitrous Oxide Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Other permit type:	Permit/License #:
Expiration date:	State:

5. Do you have healthcare clinicians (DDS/DMD, MD, CRNA) providing sedation/anesthesia on patients you are treating at your practice locations?	Yes ☐ No ☐
6. Please confirm that you comply with and have verified that those providing sedation/general anesthesia on your patients comply with your state's requirements regarding equipment, supplies, and training, which includes arranging for and ensuring the presence of required personnel who will assist in administering sedation and general anesthesia in your office.	Yes ☐ No ☐

Credentialing contact information

Contact name:	Credentialing email:
Phone number:	Fax number:

Professional questions and attestation FOR EACH "YES" RESPONSE, PLEASE INCLUDE A DETAILED WRITTEN EXPLANATION ALONG WITH THIS FORM IF A QUESTION IS NOT APPLICABLE TO YOU. PLEASE MARK "NO" FOR EACH RESPONSE	
1. Has your license(s) to practice in any jurisdiction(s), whether completed or still pending, been lost, denied, limited, suspended, revoked, not renewed; or have you been placed under probation, subjected to disciplinary action, or have you voluntarily relinquished any item in anticipation of any of these actions since original licenser date?	Yes ☐ No ☐
2. Has your professional liability insurance ever been denied, suspended, revoked, canceled or not renewed?	Yes ☐ No ☐
3. Has your federal DEA or any State Drug Certificate Registrations ever been lost, denied, suspended, canceled, or subjected to any disciplinary action?	Yes ☐ No ☐
4. Has your status as a provider, or membership with any professional organization, ever been lost, denied, suspended, disciplined, canceled, or sanctioned; or are you currently under investigation by any municipal, state, federal or any other governmental agency, or any HMO, PPO or other prepaid health plan (e.g. state or Federal Medicare or Medicaid)?	Yes ☐ No ☐
5. Are your privileges or memberships at any hospital or institution (military service) currently under investigation or have they ever been lost, denied, suspended, reduced, disciplined, or not renewed?	Yes ☐ No ☐
6. Have you ever been prevented from performing any procedures within the scope of privileges and duties as a dental care provider?	Yes ☐ No ☐
7. Do you currently, or have you ever, engaged in the unlawful use of drugs, including the improper use of prescription drugs?	Yes ☐ No ☐
8. Do you have any felony or misdemeanor charges pending against you other than a traffic violation, or have you ever been convicted of – or pleaded guilty or nolo contendere to – a felony or a misdemeanor?	Yes ☐ No ☐
9. Have you ever been involved, or are you currently involved in ANY claims/lawsuits, settlements or judgments (other than divorce or custody)?	Yes ☐ No ☐
10. Are you currently practicing WITHOUT or with EXPIRED Professional Liability/Malpractice Insurance?	Yes No
11. Do you have any conditions that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of members?	Yes ☐ No ☐

Authorization, PLEASE SIGN AND DATE

Practitioner hereby certifies that the information provided on the Credentialing Application is true and complete and correct to the best of his or her knowledge. Practitioner hereby authorizes GEHA and its authorized representatives to contact individuals and organizations to obtain information pertaining to his or her qualifications for the credentialing and any subsequent recredentialing processes. Practitioner agrees that GEHA, its subsidiaries, employees or representatives, and individuals or organizations providing information to GEHA shall not be liable for any act or omission related to the verification of the information provided in the Credentialing Application, Attestation, or Recredentialing Application process. GEHA will treat information in the Credentialing Application, Attestation, or Recredentialing Application that is not publicly available as confidential, unless disclosure is required by law, regulation or an accrediting organization. Practitioner agrees to advise GEHA of any changes in the information provided on the Credentialing Application, Attestation, or Recredentialing Application. Practitioner understand that submission of the Credentialing Application, Attestation, or Recredentialing Application does not guarantee participation or continued participation in the Connection Dental Network. A photocopy of this page shall be considered a valid authorization.

Further, Practitioner acknowledges that as part of the application process, he/she states that they (1) have reviewed Fraud, Waste, and Abuse training within the past 12 months and will review the GEHA Code of Ethical Business Conduct within 90 days of the Effective Date of the GEHA Participating Provider Agreement or (2) have read the (a) overview of the GEHA Compliance Program (b) GEHA Code of Ethical Business Conduct and (c) information on fraud, waste, and abuse, which includes my obligation to report compliance/ethics and fraud, waste and abuse concerns to GEHA. Items A, B, and C, as referenced above, can be found under the Resources Tab, www.connectiondental.com.

This space is intentionally left blank.

If my application is approved and I enter into an Individual Participating Provider Agreement with GEHA, I understand and agree to annually review the items referenced above as (a), (b), and (c) above and abide by the following compliance obligations:

1) That employees will review the materials referenced above and will be advised to report any compliance/ethics and fraud, waste and abuse concerns.
2) That any downstream entities with whom I contract for services relative to my dental practice will also be provided the materials referenced above.
3) That employees have been screened against both the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and exclusion records accessed through the System for Award Management (SAM), the system that consolidated the capabilities of CCR/FedReg, ORCA and EPLS, formally known as GSA, prior to hire or contract and monthly thereafter. Excluded individuals will be removed from providing services to Medicare Advantage plan members immediately and reported to GEHA.

Practitioner signature:	Date (required):
Printed name:	Tax ID#:
Additional contact name:	Phone:
NPI 1 (Individual):	

Connection Dental Network
PO Box 6707 | Lee's Summit, MO 64064-6707
800.505.8880, option 2
cdnapplications@geha.com | connectiondental.com

Participating Provider Agreement

THIS AGREEMENT is entered into by and between Government Employees Health Association, Inc. (hereinafter referred to as "GEHA") and Bright Smiles Dental Clinic (hereinafter referred to as "Participating Provider").

Recitals

WHEREAS, GEHA is a not-for-profit membership association that administers dental plans and has established a national network of Participating Providers called CONNECTION Dental Network; and

WHEREAS, GEHA uses the CONNECTION Dental Network in conjunction with its dental plans for its Covered Enrollees and also markets the CONNECTION Dental Network to other entities; and

WHEREAS, Participating Provider is duly licensed to engage in the practice of dentistry and desires to contract as a Participating Provider; and

WHEREAS, GEHA and Participating Provider enter into this Agreement in order to provide services to Covered Enrollees.

NOW, THEREFORE, in consideration of the foregoing and other good and valuable considerations, the parties hereby set forth their responsibilities and agree as follows:

Definitions

For purposes of this Agreement, the following terms shall have the following meanings:

"Anniversary Date" means the first day of January that begins at least one (1) year from the Effective Date.

"CONNECTION Dental Network" means the non-risk bearing dental PPO network owned and operated by GEHA.

"Covered Enrollee" means any person who is eligible to receive dental benefits offered by GEHA or an entity that has an agreement with GEHA to access the CONNECTION Dental Network.

"Credentialing and Recredentialing Policies and Procedures" are the GEHA's policies and procedures regarding the selection and deselection of providers which are updated by GEHA in its sole discretion and are available at connectiondental.com or may be requested in writing or by phone by the provider. All records related to credentialing verification for Participating Providers shall be maintained by GEHA for at least a period of five (5) years.

"Effective Date" means the date a Participating Provider is accepted in the CONNECTION Dental Network. The Effective Date will be specified in the welcome letter that is sent to the Participating Provider following credentialing approval.

"Fee Schedule" means the list of procedures with the corresponding allowable amounts for such procedures.

"Payor" means the party responsible for providing reimbursement for dental care services.

"Provider Manual" means the manual that contains the most current provider contracting provisions, network policies, and State Specific Policies and Procedures, and which may be obtained as noted below.

"State Specific Policies & Procedures" are the documents that include laws, rules, and regulations that are not already contained in this Agreement.

"Tax Identification Number" means the nine (9) digit number used as a tracking number for tax purposes.

I. GEHA Obligations

1.1 GEHA agrees to:

(a) market its CONNECTION Dental Network to other entities;

(b) maintain an administrative staff to assist the Participating Provider and his/her staff members;

(c) provide administrative reference materials regarding participation to the Participating Provider;

(d) maintain a toll-free telephone number for the use of the Participating Provider and his/her staff members;

(e) make available to Covered Enrollees, other entities, and Participating Providers a directory of Participating Providers who participate in the CONNECTION Dental Network. Directory information may be made available via paper or electronic mediums and/or toll-free telephone service. GEHA shall use its best efforts to provide current, accurate directory information;

(f) use its best efforts to arrange for the distribution of identification cards that will include the CONNECTION Dental Network logo, claim filing procedures as needed and eligibility inquiry information;

(g) submit and use its best efforts to require other Payors to submit an explanation of benefits or remittance advice that identifies the contractual source of any discount to the Participating Provider; and

(h) not interfere or intervene and use best efforts to require that other Payors not interfere or intervene in any manner in the diagnosis or treatment rendered by a Participating Provider to a Covered Enrollee or with any communication between a Participating Provider and a Covered Enrollee. Benefit determinations made by a Payor shall not constitute interference.

1.2 GEHA and Payors shall not refuse to contract with or compensate for covered services an otherwise eligible Participating Provider solely because such Participating Provider has in good faith:

(a) communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of GEHA's or Payors' health benefit plans as they relate to the needs of such Participating Provider's patients; or

(b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such provider is compensated by GEHA or a Payor for services provided to the Covered Enrollee.

1.3 GEHA and Payors shall use best efforts to make all payments due to the Participating Provider within thirty (30) days of receipt of a clean claim. GEHA shall not be an insurer, guarantor, or underwriter of the responsibility or liability of any other Payor to provide payments pursuant to any other Payor's plan.

II. Participating Provider Obligations

2.1 The Participating Provider agrees that he/she will:

(a) meet GEHA's minimum professional requirements and credentialing or recredentialing criteria; provide dental services that are consistent with standards of good dental practice in the United States; and promptly notify GEHA of any guilty plea or conviction of a felony; chronic illness, physical defect, or use of any illegal drugs or substance abuse that would impair the ability to practice;

(b) maintain an unrestricted license(s) to practice dentistry in the state where such services are to be provided; perform only those services that are within the lawful scope of any such license(s); and notify GEHA within five (5) business days in the event of the initiation of any disciplinary action of any kind taken against Participating Provider and of the ultimate disposition of such action;

(c) maintain sufficient staffing and equipment and appropriate office hours necessary to provide dental services;

(d) accept the lesser of the Fee Schedule amounts for the procedures listed on the Fee Schedule, which is attached hereto, or the Participating Provider's usual billed charges as payment in full and not balance bill Covered Enrollees for any amount in excess of the lesser of the Fee Schedule amounts for the procedures listed or the Participating Provider's usual billed charges. The Participating Provider shall be required to accept the Fee Schedule amount for all services listed on the Fee Schedule unless prohibited by law. Participating Provider shall also be required to bill Covered Enrollees for any coinsurance, copayment or deductible as permitted by a particular plan covered by this Agreement;

(e) agree that if a service is not listed on the Fee Schedule, no discount shall be taken, and the Participating Provider will be reimbursed based on the plan and the total billed charges. Nothing shall prohibit Participating Provider from pursuing any recourse against the insuring corporation, Payor or their successors;

(f) agree to cooperate with GEHA and Payors in the claims filing and coordination of benefits as determined by the benefit plans and applicable law;

(g) maintain such dental records as required by state law and provide, upon request from GEHA or other Payor and with appropriate patient authorization, copies of dental records, charging and treatment information, including x-rays and diagnostic records;

(h) be responsible for the dental care and provider-patient relationship for his/her patients. The final decision to provide or receive dental care is made between the Participating Provider and Covered Enrollee;

(i) provide dental care services and supplies to Covered Enrollees with the same quality and availability of services provided to all patients treated by the Participating Provider, and not discriminate on the basis of race, color, creed, ancestry, national origin, age, physical, mental or sensory disability, health status, religion, sex, sexual orientation, marital status, type of dental benefit plan or source of payment;

(j) furnish covered services to Covered Enrollees without regard to the Covered Enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services; however, this requirement does not apply to circumstances when the Participating Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions;

(k) maintain comprehensive general liability and malpractice insurance in amounts determined by GEHA. Such amounts shall at least meet any minimum amounts required by state law(s). The Participating Provider agrees to notify GEHA within five (5) business days of his/her receipt of notice of any adverse change in such coverage;

(l) cooperate with and follow credentialing, recredentialing and appeal procedures established by GEHA and Payors;

(m) allow GEHA, its subsidiaries, and other entities to use the Participating Provider's name, office address(es) and telephone number(s), practice information and other pertinent information in its marketing, directory information and other materials, and for regulatory purposes. Participating Provider will provide notice to GEHA within ten (10) business days of changes to his or her name, address, Tax Identification Number or practice information. All changes in Tax Identification Numbers for Participating Provider will be applied to his or her network status unless otherwise notified by Participating Provider. If Participating Provider moves to another state or zip code after initial contracting, the Fee Schedule will change to that applicable to the new state or zip code in which Participating Provider will be practicing. If Participating Provider moves or closes his or her office after initial contracting and does not notify GEHA in writing, GEHA will make a good faith attempt to locate Participating Provider; however, if GEHA is unable to locate the Participating Provider, he or she may be terminated by GEHA without written notice or cause unless prohibited by law;

(n) accept the CONNECTION Dental logo on any identification card provided to Covered Enrollees and extend the CONNECTION Dental Fee Schedule to such Covered Enrollees with the understanding that eligibility verification procedures must be followed;

(o) request, accept and maintain written assignment of benefits;

(p) maintain all dental records for a period of time as required by state or federal law but in no event less than two (2) years, and make all such records available to the administrator of the state for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to administrator beneficiaries, and to make such records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Covered Enrollees subject to applicable state and federal laws related to the confidentiality of medical or health records;

(q) continue to fulfill all obligations with respect to Covered Enrollees under his or her care as of the date of termination until the current course of treatment is complete, care of the Covered Enrollee is transferred to another Participating Provider, or as otherwise required by state or federal law;

(r) cooperate, participate in and comply with all policies and procedures and programs of GEHA or any Payor, none of which shall override the professional or ethical responsibility of the Participating Provider or interfere with the Participating Provider's ability to provide information or assistance

to their patients, and that are provided on GEHA's website at connectiondental.com or provided to Participating Provider by GEHA or Payors in accordance with applicable law;

(s) arrange for call coverage or other back-up to provide service in accordance with Payors' policies and procedures for provider accessibility as provided on GEHA's website at connectiondental.com or as provided to Participating Provider by GEHA or Payors in accordance with applicable law;

(t) comply with all applicable federal and state laws, rules and regulations, including applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), and regulations promulgated thereunder, as they may be amended from time to time; and

(u) authorize GEHA to contract with Payors, or with entities on behalf of Payors, to make Participating Provider's services available to Payors upon the same terms and conditions that such services are made available to GEHA pursuant to this Agreement.

III. General Provisions

3.1 The Effective Date of this Agreement shall be the date provided to the Participating Provider in the welcome letter.

3.2 The initial term of this Agreement shall commence on the Effective Date and terminate on the Anniversary Date as herein defined. This Agreement shall automatically renew on its Anniversary Date for additional one-year terms ending on each subsequent Anniversary Date unless terminated by GEHA or Participating Provider in accordance with Paragraphs 3.3, 3.4 and 3.5 or unless either party gives notice of its intent to terminate at the end of the then current term by providing ninety (90) days advance written notice. If this Agreement is terminated at the end of the then current term or if a Participating Provider voluntarily terminates from the CONNECTION Dental Network, the Participating Provider shall not be entitled to the procedural rights set forth in the Network Appeals/Grievances policy.

3.3 A Participating Provider's participation in the CONNECTION Dental Network shall be automatically terminated as described herein as of the date of the occurrence of the event described herein. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No provider shall be entitled to the procedural rights set forth in the Network Appeals/Grievances policy as the result of an automatic termination imposed pursuant to this section.

(a) The Participating Provider's license/authorization to practice or to prescribe controlled substances is currently revoked in any state in which the Participating Provider is or will be providing services pursuant to this Participating Provider Agreement.

(b) The Participating Provider has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any felony or any offense reasonably related to the qualifications, functions or duties of the medical profession, for any offense an essential element of which is fraud, dishonesty or an act of violence.

(c) The Participating Provider has been excluded, debarred, suspended or otherwise prohibited from participation in any state or federal health care reimbursement program including Medicare, Medicaid, TriCare or the Federal Employees Health Benefit Program (FEHBP).

(d) The Participating Provider fails to have, carry or maintain professional liability insurance as required by GEHA.

3.4 Either GEHA or the Participating Provider may terminate this Agreement, with or without cause, upon ninety (90) days' prior written notice to the other party, unless prohibited by applicable law. Termination shall be effective on the last day of the month in which the ninety (90) days' notice requirement is met. Further, this Agreement may be terminated if there is a default in the performance of the terms and conditions of this Agreement which default has not been cured within ninety (90) days following the effective date of written notice of default.

3.5 Notwithstanding Paragraph 3.4, GEHA may terminate the Agreement immediately for any of the following reasons:

(a) Any falsification of any information on the Participating Provider's application submitted to GEHA or fraud committed on any documentation; or

(b) Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s); or
(c) Institution of bankruptcy, receivership, insolvency, liquidation or other similar proceedings by or against the Participating Provider; or
(d) Any finding that a Participating Provider committed professional misconduct or caused a patient harm; or
(e) Membership in the GEHA CONNECTION Dental Network and/or privileges granted to Participating Provider are terminated, revoked, restricted, suspended, discontinued or not renewed pursuant to GEHA Credentialing and Recredentialing Policies and Procedures; or
(f) Noncompliance with HIPAA.

3.6 GEHA shall notify Participating Provider in writing of the reason for Participating Provider's involuntary termination, if applicable. Upon termination, the Participating Provider shall be entitled to those rights of appeal or grievance as set forth in the policies and procedures of GEHA if Participating Provider is entitled to such appeal or grievance pursuant to said policies and procedures. Further, Participating Provider shall not be entitled to such appeal and grievance policies and procedures if such policies and procedures have previously been implemented with respect to Participating Provider. If applicable, GEHA and Participating Provider agree to follow such policies and procedures. Notwithstanding other provisions in this Article III, GEHA and Participating Provider agree to abide by the laws of any applicable state which may apply to terminations. Participating Provider shall be obligated to complete a course of treatment begun prior to the effective date of termination.

3.7 In the event of insolvency of GEHA or Payor or other cessation of operations, benefits to Covered Enrollees will continue through the period for which the premium has been paid, if applicable, and Participating Provider will cooperate in the transition of administrative duties and records to the succeeding company or provider, as the case may be. The liability of a party to this Agreement may not be transferred to another party or to Covered Enrollees. Participating Providers are not required to indemnify Payors for any expenses or liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges incurred in connection with any claim or action brought against the Payor based on the Payor's management decisions, utilization review provisions or other policies, guidelines or actions. Nothing in this section, however, shall in any way affect or limit Participating Provider's right or obligation to collect deductibles, coinsurance, or copayments, as specifically provided in the plan, or fees for non-covered services delivered to Covered Enrollees. This provision shall survive termination of this Agreement for services rendered prior to the termination of this Agreement, regardless of the cause of the termination.

3.8 GEHA may increase all or part of the Fee Schedule at any time without notice to the Participating Provider. GEHA may not decrease the Fee Schedule unless the Participating Provider is notified in writing sixty (60) days prior to the effective date of the decrease or as otherwise required by law.

3.9 GEHA will post provider notifications on its website at connectiondental.com and will accept changes to Participating Provider's license or credentialing information, malpractice insurance or other practice information in writing through its website form at connectiondental.com under "Contact Us," by facsimile at 816.257.4439, or by regular mail at the address below the signature block of this Agreement.

3.10 GEHA and Participating Provider agree that both parties shall at all times be acting and performing as independent contractors. This Agreement shall not be construed to create any relationship of employer and employee, partners, joint venturer or principal and agent.

3.11 This Agreement and any attachments represent the entire agreement and understanding between GEHA and Participating Provider, and supersedes and replaces any previous Participating Provider Agreement entered into by the parties. The Agreement shall automatically be amended to comply with changes in state or federal law.

3.12 GEHA and other Payors shall comply with all applicable federal and state laws, rules and regulations, including applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), and regulations promulgated thereunder, as they may be amended from time to time. With regard to the operation of the GEHA dental plans, state law is specifically preempted and all matters relating to benefits or the payment of benefits by

3.12 GEHA shall be resolved by the United States Office of Personnel Management (OPM) with respect to the Federal Employee Dental and Vision Benefits Program dental plan and in accordance with the disputed claims procedures and the regulations of the OPM or in accordance with the GEHA benefit plan dispute resolution procedures with respect to the Connection Dental Plus dental plan. Any applicable federal and state laws, rules and regulations not specifically mentioned in this Agreement are contained in CONNECTION Dental Network's State Specific Policies & Procedures in its Provider Manual as may be amended from time to time, are hereby incorporated by reference into this Agreement, and are available at connectiondental.com or upon request. If the terms of this Agreement conflict with the State Specific Policies & Procedures established by GEHA with regard to applicable federal and state laws, rules and regulations, the State Specific Policies & Procedures shall prevail.

3.13 If required by applicable law, Payors shall notify Participating Providers of their responsibilities with respect to such Payor's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, and confidentiality requirements by making such policies and programs available to Participating Providers on CONNECTION Dental Network's website at connectiondental.com under the "Payor Info" tab or available from the Payor upon request by the Participating Provider. Any notifications required by applicable law to be provided to Participating Providers by Payors shall also be posted on the CONNECTION Dental Network website under the "Payor Info" tab and if required, shall be submitted to Participating Providers in writing, except that required Fee Schedule notifications shall be sent by GEHA to Participating Providers. CONNECTION Dental Network's documents, procedures, and other administrative policies and programs referenced in this Agreement are available for review by providers at connectiondental.com or available upon request. All information made available to a Participating Provider in accordance with the requirements of applicable state or federal law shall be confidential and shall not be disclosed to any individual or entity not involved in the provider's practice or the administration of such practice without the prior written consent of GEHA.

3.14 GEHA, Participating Provider, any other Payor or entity, or any of their respective employees or agents shall not be held liable for any negligence or intentional wrongdoing on the part of another or any costs, expenses or attorneys' fees associated therewith.

3.15 GEHA is not liable for any claims for services provided by a Participating Provider to a Covered Enrollee who is entitled to benefits payable under any other plan other than covered services under the GEHA Plan, which operates pursuant to the FEHBP, or CONNECTION Dental Plus.

3.16 GEHA and Participating Provider agree that both parties shall maintain patient record confidentiality and not disclose any such patient information without the patient's written consent or as otherwise permitted by law.

3.17 In the event that any dispute arises with regard to the performance or interpretation of any of the provisions of this Agreement, GEHA and Participating Provider shall use best efforts to resolve such disputes. In the event such disputes cannot be resolved between GEHA and Participating Provider, such disputes shall be submitted to an arbitrator selected by the American Arbitration Association unless prohibited by applicable law, in which case applicable law shall govern this section. GEHA and Participating Provider agree to be bound by the decision of the arbitrator and accept the decision as the final determination. Judgment upon decision of the arbitrator may be entered in any court of competent jurisdiction. GEHA and Participating Provider shall each bear its own cost plus one-half (1/2) the cost of arbitration. Disputes regarding benefits or the payment of benefits for services provided to Covered Enrollees are excluded from coverage under this provision and shall be resolved in accordance with the Payors' appeals processes. Also, issues involving the termination of Participating Provider and any appeals or grievances related thereto are covered by policies and procedures of GEHA and are not covered by this arbitration provision.

3.18 This Agreement shall be governed by and construed in accordance with the laws of the State of Missouri and any applicable federal law(s). The substantive law of Missouri shall solely govern this Agreement and no cause of action not specifically recognized in the State of Missouri shall be implied or construed to exist.

3.19 To the extent that this Agreement allows for sub-contracting with providers and facilities, all sub-contracts will be subject to the terms of this Agreement and all applicable federal and state laws, rules and regulations.

3.20 CONNECTION Dental Network's Provider Manual is available at connectiondental.com, may be requested in writing at the address below, or may be requested by telephone by calling 800.505.8880. The Provider Manual contains additional information about state-specific laws and regulations regarding appeal and grievance procedures, termination procedures, dispute resolution processes, network participation procedures, quality of care/services procedures, claims procedures, provider-patient relationships, and required content in the contract. The manual also contains information about how providers can update their information and the initial credentialing and recredentialing criteria for providers for purposes of network participation.

THIS CONTRACT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the undersigned have executed this Agreement to be effective in accordance with paragraph 3.1 of this Agreement.

PARTICIPATING PROVIDER

Emily Carter, DDS

(Printed Name of Provider)

By: _____

(Signature of Provider)

Date: 01/15/2026

License #: TX-D23456 License State: TX

Tax ID: 98-7654321

Primary Practice Address: 456 Innovation Drive, S

Austin, TX 78701

Phone: 512-555-0182 Fax: 512-555-0183

Email: contact@brightsmilesaustin.com

GOVERNMENT EMPLOYEES HEALTH ASSOCIATION, INC.

By: _____

Shannon Cooper, Vice President
Dental Networks & Plans

Date: _____

GEHA/CONNECTION Dental Network

Address:
310 NE Mulberry Street
P.O. Box 6707
Lee's Summit, MO 64064-6707

Phone: 800.505.8880

Fax: 816.257.4439

Email: **connection.dentalweb@geha.com**