ADDENDUM TO PROVIDER AGREEMENT

NEW ASSOCIATE DENTIST

The following is notification to SPDO to include the dentist(s) listed below as associates in the practice. All dentists listed are to be included under the terms of the original SPDO Provider Agreement and will provide services to the patients belonging to dental plans included in this Agreement.

Name of Practice: ______________________________

Address: ______________________________

____
City State Zip Code

Phone: ______________________ Fax: ______________________

New Associate Dentist Name(s): Specialty:

______________________ ______________________

______________________ ______________________

______________________ ______________________

NEW OFFICE LOCATION

The following is notification to SPDO to include the office listed below in the original SPDO Provider Agreement.

Name of Practice: ______________________________

Address: ______________________________

____
City State Zip Code

Phone: ______________________ Fax: ______________________

TAX ID NUMBER: ______________________________

Participating Dentist (s) at new location: Specialty:

______________________ ______________________

______________________ ______________________

______________________ ______________________

____

Signature of Owner of Practice or authorized representative (must have letter of authorization from owner)

____

Print Name/Title

____

Date

FOR SPDO USE ONLY	**ACCEPTANCE** By ______________________ (SPDO Authorized Signature) Title ______________________ ______________________ (Print Name) Date ______________________

SPDO PROVIDER PROFILE

Complete for Each Dentist

Provider Name ____

Office Name ____

Office Address ____
City State Zip Code

E-Mail Address ____

Date of Birth ______________________ **Social Security Number** ______-_______-______

A. Credentials

1. Dental School_________________________ Year Grad. _____________________
2. Years in Practice _____ License # _______________ A.D.A. Member? __________
3. DEA License # _____________________ NPI # _________________________

B. How long have you practiced at this location? _________________________________

C. Dentist treatment hours at this location

Monday __________ Wednesday __________ Friday __________
Tuesday __________ Thursday __________ Saturday __________
Sunday __________

D. Are these current hours of treatment? Yes ☐ No ☐

Please list names and locations of practices you've practiced at for the past 5 years.

	NAME OF PRACTICE	LOCATION	DATES
Current:	_________________________	_________________________	______
	_________________________	_________________________	______
	_________________________	_________________________	______
	_________________________	_________________________	______

If currently working at another practice, do you plan on continuing to work there after the date of this application? Yes ☐ No ☐

E. Insurance

1. Professional Liability Insurance Company
____
2. Policy # ________________________ Expiration Date ________________________
3. Coverage Amount $ ____________________

F. Additional Locations this Dentist is Practicing at:

1) ____

2) ____

3) ____

4) ____

G. Please list any languages other than English that are spoken by the Dentist.

____

H. Procedure Profile

Services the **Dentist listed on the first page of Provider Profile** routinely performs

		YES	NO
1.	**Periodontic**		
a.	Scaling and Root Planing	______	______
b.	Osseous Surgery	______	______
2.	**Crowns/Bridges/Dentures**		
a.	Fixed Crown and Bridge	______	______
	Type of Metal Offered: (check all that apply)		
	(Crown) _______ Base _______ Noble _______ High Noble		
	(Bridge) _______ Base _______ Noble _______ High Noble		
b.	Removable Partial and Full Dentures	______	______
3.	**Endodontics**		
a.	Single Canal	______	______
b.	Two Canals (uncomplicated)	______	______
c.	Three Canals (uncomplicated)	______	______
d.	Four Canals (uncomplicated)	______	______
	(If you check no and are in a multi-doctor practice, will you refer to another general dentist within the practice to do the above procedure(s)?)	_______	______
4.	**Oral Surgery**		
a.	7140 Simple Extractions	______	______
b.	7210 Surgical Extractions erupted tooth	______	______
h.	9220 General Anesthesia	______	______
i.	9240 IV Sedation	______	______
j.	Nitrous Oxide	______	______
	(If you check no and are in a multi-doctor practice, will you refer to another general dentist within the practice to do the above procedure(s)?)	______	______

		YES	NO
5.	**Pediatric Dentistry**		
a.	Does this office perform most services needed by children? If no, please explain under "Comments."	______	______
b.	List minimum age of children that you see:	______	

Comments:

____

____

____

I. Board Profile (If answer yes to questions I 3-5, list in comments below.)

1. Board Eligible ______ Date ____________________ No. _____________________
2. Board Certified ______Date ____________________ No. _____________________
3. Malpractice Incidents within the last five (5) years? Yes ☐ No ☐
4. Has your dental license issued from any state been suspended or revoked within the last five (5) years? Yes ☐ No ☐
5. Has any disciplinary action has been taken against you by any State Board of Dentistry within the past five (5) years? Yes ☐ No ☐

Comments for Questions I 3 – 5

____

____

____

Signature of Provider: ___________________________________ Date: _____________________

***** By signing I verify that the above Board Profile information is accurate*****

GENERAL RELEASE OF INFORMATION AUTHORIZATION

I have applied to Southwest Preferred Dental Organization (SPDO) for eligibility as a Plan Provider. I hereby authorize SPDO, its representatives, and Designees to consult with the administration and members of the staffs of institutions, professional licensing bodies, professional liability insurance carriers and professional organizations with which I have been associated and with others who may have information bearing on my professional competence, character and ethical qualifications. I hereby consent to the inspection by SPDO, its representative and Designees of all documents and information that may be material to an evaluation of my professional qualifications and competence.

By signing this authorization, I release from liability all representatives or Designees of SPDO, as well as all representatives of institutions, professional licensing bodies, professional organizations for their acts performed in good faith and without malice in connection with both the exchange of information as consented to above, as well as in connection with evaluating my application, my credentials and my qualifications.

A photocopy of this authorization is to be accepted with the same authority as this original.

____
Signature

____
Print Name

____
Name of Practice

____
Date