UNITED CONCORDIA DENTAL EDI
ENROLLMENT FORM

Name of Dentist or Group: _____

Provider #: _____

Address: _____

_____

City: _____ State: _____ ZIP: _____

Contact: _____ Phone #: ( ) _____

Check claim types you wish to submit electronically:

UCCI
ConcordiaPLUS
DentalPLUS
Pennsylvania Blue Shield
TRICARE Active-Duty Family Member Dental Plan

Please check one:

Existing electronic biller adding this new provider to source # 94__ __ __ __
New electronic biller using the following clearinghouse or billing service: _____
New electronic biller using the following software vendor: _____

AGREEMENT

A. When submitting Dental claims electronically to United Concordia Companies, Inc. (UCCI), **THE PROVIDER AGREES:**

1. That it will be responsible for all Dental claims submitted to UCCI by itself, its employees, or its agents.
2. That it will not disclose any information concerning a Dental subscriber/sponsor to any other person or organization except UCCI without the express written permission of the Dental subscriber/sponsor or his/her parent or legal guardian, or where required for the care and treatment of a subscriber/sponsor who is unable to provide written consent, or to bill insurance primary or supplementary to Dental, or as required by State or Federal law.
3. That it will submit claims only on behalf of those Dental beneficiaries who have given their written authorization to do so, and to certify that required subscriber/sponsor signatures, or legally authorized signatures on behalf of beneficiaries, are on file.
4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect subscriber/sponsor's name, subscriber/sponsor's dental insurance claim number, date(s) of service, and procedure/service performed.
5. UCCI has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the subscriber/sponsor's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to UCCI guidelines.
6. That it will ensure, to the best of its ability, that all claims for UCCI primary payment have been developed for other insurance involvement and that UCCI is the primary payer.
7. That it will submit claims that are accurate, complete, and truthful.
8. That it will retain all original source documentation and medical record pertaining to any such particular Dental claim for a period of at least 6 years, 3 months after the bill is paid.
9. That it will use sufficient security procedures to ensure all transmissions of documents are authorized and protect all subscriber/sponsor-specific data from improper access.
10. That it will acknowledge that all claims will be paid from UCCI funds, that the submission of such claims is a claim for payment under one of the UCCI programs, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal, State and Local law.
11. That it will establish and maintain procedures and controls so that information concerning Dental beneficiaries, or any information obtained from UCCI shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with § 1106 (a) of the Act).
12. That it will research and correct claim discrepancies.
13. That it will notify UCCI within 2 business days if any transmitted data are received in an unintelligible or garbled form.
14. That by enrolling to submit Dental claims electronically to UCCI, it remains responsible for those claims. In accepting claims submitted electronically to UCCI from any billing service or through the use of a particular product

which accomplishes this process, UCCI is not attesting to the appropriateness of the methods used by the billing service or to the accuracy of a particular vendor's product which purportedly facilitates such electronic submissions. The provider furnishing the item or service for whom payment is claimed under UCCI retains the responsibility for any claim regardless of the format in which it chooses to submit the claim.

B. UNITED CONCORDIA COMPANIES, INC. WILL:

1. Transmit to the provider an acknowledgment of claim receipt.
2. Affix the intermediary/carrier number, as its electronic signature on each remittance advice sent to the provider.
3. Ensure that payments to providers are timely in accordance with UCCI's policies.
4. Ensure that no contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor will make alternative means available to the provider to obtain such services.
5. Ensure that all Dental electronic billers have equal access to any services that UCCI makes available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services UCCI sells directly, indirectly, or by arrangement.
6. Notify the provider within 2 business days if transmitted data is received in an unintelligible or garbled form.

NOTICE: Federal, State or Local law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by UCCI under this document. This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Dental claims are submitted to UCCI. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. SIGNATURE: I am authorized to sign this document on behalf of the indicated party. I have read and agree to the foregoing provisions and acknowledge same by signing below:

Signature _____

Printed Name _____ DATE _____