New Dental Clinic/Group Application

Arkansas Blue Cross and Blue Shield • Health Advantage • USAble Corporation

Please fax to 501-208-8302 or email to dentalproviderrelations@usablelife.com
Forms can also be mailed to: Dental Provider Network Operations
PO Box 1650 Little Rock AR 72203.

Name of Clinic/Group

_____

Signage name displayed to patients (if different from above)

_____

Effective Date _____Clinic/Group EIN _____
(Attach IRS verification of EIN)

Clinic/Group NPI# _____

- Street Address of Clinic/Group _____

  _____ County_____

  Phone # for Patient Appointments _____

  Clinic/Group Fax # _____

  Contact Person _____Contact Phone # _____

  Contact Email: _____

  Office hours at this location-

  Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close

  Mon. _____ Tues. _____Wed_____ Thurs._____ Fri._____ Sat._____ Sun._____

  Web URL_____

- Correspondence Address of Clinic/Group_____
  (If different than above) _____
  *County*_____

  Correspondence Phone #_____

  Clinic/Group Fax # _____

  Contact Person _____Contact Phone # _____

- Payment Address of Clinic/Group

  _____
  (If different than above)
  _____*County*_____
  _

  Payment Phone # _____

  Clinic/Group Fax # _____

  Contact Person _____Contact Phone # _____

_____ Title _____
Print Name and Title of Authorized Facility Representative

Signature _____ Date _____
NO STAMPS OR DIGITAL SIGNATURES

Additional Locations

- Location Name ____

  Address ____

  Phone ______________________ Fax ______________________

  Office hours at this location-

  Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close

  Mon. _______ Tues. ________Wed__________ Thurs._________ Fri.___________ Sat.________ Sun.________

- Location Name ____

  Address ____

  Phone ______________________ Fax ______________________

  Office hours at this location-

  Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close

  Mon. _______ Tues. ________Wed__________ Thurs._________ Fri.___________ Sat.________ Sun.________

- Location Name ____

  Address ____

  Phone ______________________ Fax ______________________

  Office hours at this location-

  Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close

  Mon. _______ Tues. ________Wed__________ Thurs._________ Fri.___________ Sat.________ Sun.________

- Location Name ____

  Address ____

  Phone ______________________ Fax ______________________

  Office hours at this location-

  Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close

  Mon. _______ Tues. ________Wed__________ Thurs._________ Fri.___________ Sat.________ Sun.________

* This form may be copied for any additional locations

Authorization Form for Clinic/Group Billing

Arkansas Blue Cross and Blue Shield • Health Advantage • USAble Corporation
(Complete for Each Provider Working at Clinic)

Name _____ NPI #_____
(*Print Name of Individual Practitioner)* *(Individual Practitioner)*

Name of Clinic/Group _____

Date Practitioner Joined Clinic/Group _____ Clinic/Group EIN _____
(Attach IRS verification of EIN)

Clinic/Group NPI # _____

- Street Address of Clinic/Group _____
  Phone # for Patient Appointments _____ Clinic/Group Fax # _____
  Contact Person _____Contact Phone # _____

- Correspondence Address of Clinic/Group _____
  (If different than above)
  Correspondence Phone #_____ Clinic/Group Fax # _____
  Contact Person _____Contact Phone # _____

- Payment Address of Clinic/Group _____
  (If different than above)
  Payment Phone # _____ Clinic/Group Fax # _____
  Contact Person _____Contact Phone # _____

The undersigned hereby authorizes Clinic/Group named above, or any of its duly authorized administrators, to accept on the undersigned's behalf any assignment or direct payment for services rendered by undersigned at such clinic/group that are covered under the following contracts:

- **Arkansas Blue Cross and Blue Shield Preferred Payment Plan**
- **USAble Corporation True Blue PPO**
- **USAble Corporation Arkansas' FirstSource® PPO**
- **HMO Partners, Inc. (d/b/a Health Advantage)**
- **Medi-Pak® Advantage PFFS**
- **Medi-Pak® Advantage LPPO**
- **Medi-Pak® Advantage HMO**

This authorization applies to all moneys due under the agreements designated above, including payment for healthcare services and any risk-sharing settlements, if applicable. The undersigned retains the right to revoke this authorization by giving 30 days prior written notice to Provider Network Operations, Attention Clinic/Group Billing Authorization. The undersigned understands and agrees that the Clinic/Group named above can likewise refuse to accept payment(s) authorized by this assignment. Payments for services rendered at above named Clinic/Group and due after Provider Network Operations receives the written notice of revocation of this authorization from the undersigned or refusal to accept payments from the Clinic/Group, shall be paid direct to undersigned, provided, however, that the following additional terms shall apply: (a) following execution of this Authorization, neither Arkansas Blue Cross and Blue Shield nor any other payer accessing the PPO or HMO networks (hereafter collectively referred to as "Payers") shall be obligated to redirect payment to any other location or recipient except upon 30 days' prior written notice; (b) Payers shall be entitled to require satisfactory proof of signatures and authority to redirect payment; (c) in the event of a dispute between clinic/group and the undersigned or between the undersigned and any other party regarding right to receipt of any payment, Payers may, in their sole discretion, either hold all payments until such Payers deem the dispute resolved, or Payers may make payment to clinic/group, in which case the undersigned agrees to look solely to clinic/group with respect to any claims for payment, and the undersigned hereby releases Payers from any liability with respect to such payments. By signing this form, the undersigned expressly agrees to the preceding terms and conditions of clinic/group billing.

Signature _____Date _____
(Individual Practitioner- NO STAMPS)