

**Savon Dental Plan<sup>®</sup>**  
*America's Dental Plan*

**Nationwide Network  
Specialist  
Enrollment Guide**

**Covers All Zones For  
Specialists —  
Discounted Fees Only**

**(602)841-3494 • Text Only (623)309-7247**

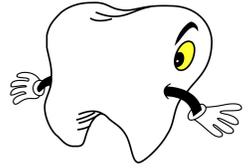
**Corporate Office: Show Low, Arizona**

**Mailing Address: PO Box 63 • Show Low, AZ 85902**

**Website: [www.SavonDentalPlan.com](http://www.SavonDentalPlan.com)**

**Email: [ProviderServices@SavonDentalPlan.com](mailto:ProviderServices@SavonDentalPlan.com)**

# Provider Participation Made Simple!



## Step 1

*Agree to discount your own Usual and Customary fee by 25% for all Savon Dental Plan® members that present a current membership identification card.*

*25% discount is from your own Usual and Customary Fee for the entire treatment plan.*

*Lab fees and metal charges are never discounted.*

## Step 2

*Complete the Credentialing Check List for the Dental Center*

*Please make sure that you are submitting all of the following items.*

*For each Specialist Office please submit:*

*[ ] COMPLETED, SIGNED and DATED PROVIDER AGREEMENT*

*[ ] The COMPLETED two (2) page CENTER PROFILE*

*Please Note: If you have more than one (1) dental center, the two (2) page Center Profile is required for each center. Copies of these pages are permissible*

## Step 3

*Complete the Credentialing Check List for the Dentist*

*Please make sure that you are submitting all of the following items.*

*For each provider please submit:*

*[ ] The COMPLETED one (1) page PROVIDER PROFILE*

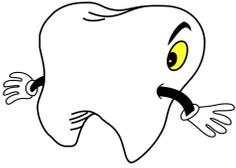
*We only require numbers and expiration dates of the following items, we do not require copies of them.*

*[ ] PROFESSIONAL LIABILITY INSURANCE POLICY NUMBER AND EXPIRATION DATE*

*[ ] STATE DENTAL LICENSE NUMBER AND EXPIRATION DATE*

*[ ] DEA CERTIFICATE LICENSE NUMBER AND EXPIRATION DATE*

*Please Note: Please submit separate credentialing information for each provider at your facility. Copies of this page are permissible.*



## Specialist Provider Agreement

This Provider Agreement made and entered into this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by and between \_\_\_\_\_, hereinafter referred to as "Provider" and Savon Dental Plan, a membership dental provider organization, hereinafter referred to as "Plan".

Plan and Provider agree to the following:

Plan has a dental network to provide dental care to individuals, families, groups, businesses and eligible dependents of the aforementioned, (hereinafter referred to as "Members"). Provider agrees to provide care for the Members according to this agreement providing Member is able to provide proof of current membership in the plan.

**RENDITION OF CARE:** Provider agrees to render necessary dental services to each of the Members covered by Plan Agreement. Such rendition of services shall occur during his/her regular office hours, subject to prior appointments, provided, however, that Provider shall have the right within the framework of professional ethics to reject any patient seeking his/her professional services.

**ELIGIBILITY:** All determinations as to the eligibility of any person for benefits under a Plan Agreement, or the standing of any person with respect to membership in any group entitled to benefits under a Plan Agreement shall be determined by the Plan before the Provider renders any dental services. Provider shall make telephone contact with the Plan or verify eligibility via the internet, before delivering service to Members to confirm current membership and subscriber identification number.

**DISCLOSURES AND REIMBURSEMENTS:** This plan is NOT insurance. Savon Professional Services Inc., Savon Dental Plan is "discount medical plan organization," "DMPO" and is not an insurance company. We will not reimburse any member or doctor for any fees listed on the schedule of benefits, prescriptions or any fees that are not listed. No portion of any provider's fee will be reimbursed or otherwise paid by Savon.

**FEES DUE DIRECTLY FROM MEMBER:** Specialists shall reduce by 25% from Specialist's own usual and customary fee for any treatment provided for any Member of Plan. Specialist is not required to provide any treatments at no charge.

**USE OF PROVIDER NAME:** Provider consents to the inclusion of his/her name and facility information in Plan's Provider Directories, both print and electronic.

**CHANGE IN SCHEDULE OF BENEFITS AND OTHER TERMS:** It is specifically understood that the benefits, terms, and conditions of the Agreement between the Plan and Provider may be changed from time to time during the term of this Provider Agreement. Plan agrees to notify Provider in writing of the nature of such changes to the extent such changes affect the terms of this Provider Agreement.

If a modification is augmented Provider has ten (10) days to accept or decline such modification. Unless, within ten (10) days after receipt of such notification, Provider notifies Plan in writing that he/she declines to provide dental services to the Members in accordance with the changed Plan Agreement; Provider agrees to continue to perform dental services under the modified Plan Agreement and this Provider Agreement shall be deemed amended accordingly.

**STANDARD OF CARE:** Provider agrees that he/she shall perform his/her obligations under this Provider Agreement in accordance with high standards of competence, care and concern for the welfare and needs of the Members in accordance with the "principles of ethics" of the American Dental Association and the Dental Practice Act of the State in which Provider is licensed. It is understood that the inclusion of Provider on the panel of the Plan is not a recommendation of Provider by the Plan.

**NON – EXCLUSIVE:** This Provider Agreement is not exclusive in any respect. Plan is entitled to enter into similar agreements with other parties, or with other dentists. Provider is free to enter into similar agreements with other parties, or with other groups not represented by Plan.

**PROVIDER PATIENT RELATIONSHIP:** Provider shall maintain the dentist-patient relationship with Members and shall be solely responsible to the patient for dental advice and treatment. It is expressly agreed between the parties that the Provider is an independent contractor and quality control issues notwithstanding, the Plan shall not have any dominion or control over the Provider's practice, the dentist patient relationship, his/her personnel or facilities.

**MALPRACTICE:** Provider agrees to carry malpractice insurance in at least an adequate amount which is usual and customary in their state.

**ASSIGNABILITY OF AGREEMENT:** This Provider Agreement, being intended to secure the personal services of Provider and dentists associated with Provider, shall not be assigned or transferred without written consent of Plan.

**COMPENSATION TO DENTIST/PROVIDER:** Provider understands that there is no capitation involved in the Plan's dental program. Provider further agrees and understands that the total Member's financial obligation shall not exceed the fees listed on the Schedule of Fees and Benefits attached in this packet and made part of this Agreement.

**DURATION OF AGREEMENT:** Provider participation in this Provider Agreement shall be an on-going continual agreement with Plan that may be terminated by either party with a Thirty (30) day written notice mailed by registered or prepaid certified mail to the last known address of the other party. Provider agrees that upon termination of this agreement, he/she will continue to accept patients of record until all on-going treatments are completed. Such termination shall have no effect upon the rights and obligations of the parties arising out of any transaction occurring prior to the effective date of such termination and any continuing obligations after the termination as set forth herein. Suspension or termination of Provider's Dental license, or failure to adhere to any section of this agreement may result in immediate termination for cause of this Agreement.

**NOTICE TO MEMBERS OF TERMINATION OF AGREEMENT:** In the event that this Provider Agreement is terminated by either party, in accordance with the procedures set forth herein, Plan will, to the best of its ability, notify all Members assigned to Provider that the Agreement between Plan and Provider has been terminated and will, to the best of its ability, transfer all Members to a new Provider.

Provider agrees that at the time the patient seeks an appointment, he/she will notify Member prior to providing any dental service that the Agreement is no longer in effect. In the event such notice is not given to the patient, Provider agrees to accept payment for his/her services at a rate no more than set forth in the aforementioned this agreement.

**RULES OF ADJUDICATION:**

Plan and Provider agree that if any part of this agreement is found to be in violation of any law of any State within the United States of America, only the section(s) that violate the law shall be voided. The rest of this agreement shall remain intact and enforceable at all times.

Plan and Provider agree that if any action by either party caused or may cause harm to the other party that forces the injured party to initiate litigation, such litigation shall be filed and adjudicated within the State of Arizona, Maricopa County. Plan and Provider agree that the aforementioned State and County shall at all times be the proper venue for any legal actions.

**IF SIGNING AS AN INDIVIDUAL PRACTITIONER**

**IF SIGNING ON BEHALF OF A GROUP/CORPORATION**

By \_\_\_\_\_  
(Dentist's/Provider's Signature) Authorized Signature)

By \_\_\_\_\_

\_\_\_\_\_  
(Dentist's/Provider's Name – Please Print)

\_\_\_\_\_  
(Name/Title of Above – Please Print)

Date \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
(Name of Individual Practice – Please Print)

\_\_\_\_\_  
(Name of Group or Corporation – Please Print)

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Email Address

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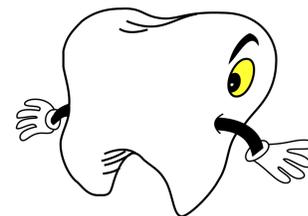
**PLEASE DO NOT WRITE BELOW THIS LINE**

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Date Received: \_\_\_\_/\_\_\_\_/20\_\_\_\_ Credential Check Cleared [ ] Yes [ ] No Approved [ ] Denied [ ] Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

\_\_\_\_\_  
C. Parker Director of Provider Relations

# Specialist Center Profile



## *Please Tell Us About Your Office*

What is the name of your practice? \_\_\_\_\_

What is the physical address of the Office? \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

What is the office phone number?(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax Number?(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

What is the name of your office manager or appointment coordinator? \_\_\_\_\_

Office Manager's email address: \_\_\_\_\_

Do you have a Web Site?  Yes  No If yes please give us your web address: www. \_\_\_\_\_

If you have a web site would you like a link from our dentist list to your web site?  Yes  No

Is your office in a Metropolitan Area (over 100,000 people)  Yes  No (If no) miles from a Metro Area? \_\_\_\_\_ miles

Are languages other than English spoken in your office?  Yes  No (if yes, please specify) \_\_\_\_\_

Is the mailing address the same as the physical address?  Yes  No (If no, please give us the mailing address below).

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## *Please Tell Us About Your Operatories and Patient Capacity*

How many operatories do you have? \_\_\_\_\_ How many assistants do you have? \_\_\_\_\_

Do you have a hygiene department?  Yes  No (if yes) How many hygienists do you have? \_\_\_\_\_

How many additional patients is your office willing to accommodate on a monthly basis? 10-20 21-50 51-70 71-90 91-100 over 100

(please circle the one that applies)

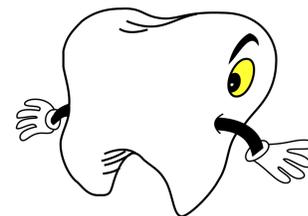
## *Please Tell Us About Options and Special Equipment that you have*

(please check all that apply to your office)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Nitrous Oxide   | <input type="checkbox"/> Ultra Sonic Cleaning    | <input type="checkbox"/> Laser               | <input type="checkbox"/> Electro Surge              |
| <input type="checkbox"/> IV Sedation     | <input type="checkbox"/> Oral Sedation           | <input type="checkbox"/> Prophy Jet          | <input type="checkbox"/> Denta Cam                  |
| <input type="checkbox"/> K.C.P. 2000     | <input type="checkbox"/> Brite Smile/Zoom (etc.) | <input type="checkbox"/> High Speed Endo     | <input type="checkbox"/> Digital X-Ray              |
| <input type="checkbox"/> Cavitron        | <input type="checkbox"/> Children Sedation       | <input type="checkbox"/> On site denture Lab | <input type="checkbox"/> On site Crown & Bridge Lab |
| <input type="checkbox"/> Panoramic x-ray | <input type="checkbox"/> Diode Laser             | <input type="checkbox"/> CAD/CAM (Cerec)     | <input type="checkbox"/> 3D Imaging                 |

Other (please explain): \_\_\_\_\_

# Specialist Center Profile



Page II

## **Please Tell Us What Days and Hours You are Open**

Days Open:  Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

Office Hours: \_\_\_\_-\_\_\_\_ \_\_\_\_-\_\_\_\_ \_\_\_\_-\_\_\_\_ \_\_\_\_-\_\_\_\_ \_\_\_\_-\_\_\_\_ \_\_\_\_-\_\_\_\_ \_\_\_\_-\_\_\_\_

## **Please Tell Us About Your Payment Policy**

Please check the credit cards that you accept:  Mastercard  Visa  American Express  Discover

Do you accept any other credit cards?  Yes  No (if yes, please specify) \_\_\_\_\_

Please check any of the following other forms of payments that you make available to patients

Personal Checks  Care Credit  "In house" financing  Payment plans available through a finance company

Other (please explain): \_\_\_\_\_

## **Equipment Sterilization and Infection Control**

Do you sterilize your instruments in office?  Yes  No (if yes) Type:  Autoclave  Chemclave  Statem  Steam  Cold  Other

Do you sterilize your handpieces in office?  Yes  No (if yes) Type:  Autoclave  Chemclave  Statem  Steam  Cold  Other

Do you spore test your sterilization unit?  Yes  No (If yes) how often?  Daily  Weekly  Monthly  Other

If other or no is checked for any of these questions please explain: \_\_\_\_\_

## **Personal Sterilization and Infection Control that is Used in this Office**

In the Operatory, Do you wear: Mask  Yes  No Gloves  Yes  No

Eye Protection  Yes  No  As Needed Protective Clothing  Yes  No  As Needed

## **Emergency Control Procedures**

Is your office equipped with Oxygen  Yes  No Is your office equipped with a Blood Pressure Device  Yes  No

Is your office equipped with a Defibrillator  Yes  No Does your office have at Least 1 C.P.R. Certified Person  Yes  No

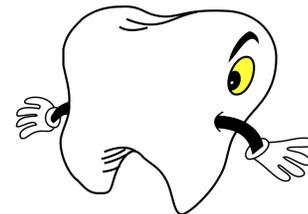
## **Compliance Procedures**

Does your office Meet O.S.H.A. Standards  Yes  No Does your office Have a Written Infection Control Policy  Yes  No

Does your office Have a Written Hazard Control Policy  Yes  No Does your office have a written H.I.P.P.A. policy  Yes  No

Is your office able to accommodate patients with Disabilities (Special question for our disabled members)  Yes  No

# Specialist Provider Profile



*(A separate profile is required for each provider)*

**Please type or print clearly - All information is required unless noted otherwise**

What is your name? \_\_\_\_\_ D.D.S. or D.M.D. Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Emergency or Cell Phone Number: (\_\_\_\_) \_\_\_\_\_ What is your EMAIL address? \_\_\_\_\_

What Dental College did you graduate from? \_\_\_\_\_ In What Year? \_\_\_\_\_

What Dental School did you receive your specialty training? \_\_\_\_\_

Are you Board Certified?  Yes  No (if yes) What year were you certified? \_\_\_\_\_ In what State \_\_\_\_\_

What is your License Number? \_\_\_\_\_ State: \_\_\_\_\_ When does it expire? \_\_\_\_ / \_\_\_\_ /20 \_\_\_\_

Who is your Professional Liability Insurance Carrier? \_\_\_\_\_

What is your Policy Number? \_\_\_\_\_ When does your policy expire? \_\_\_\_ / \_\_\_\_ /20 \_\_\_\_

What is your D.E.A. Number? \_\_\_\_\_ When does it expire? \_\_\_\_ / \_\_\_\_ /20 \_\_\_\_

What is the name of your practice? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have any Dental Board problems that we should know about?  Yes  No (if yes; please use additional paper to explain)

**NOTE: A yes answer to the above question DOES NOT automatically disqualify you from participation in our plan.**

**What is your area of Specialty? (Check all that apply)**

Orthodontics       Pedodontics       Endodontics       Prosthodontics

Oral Surgery       T.M.J.       Periodontics       Implants

**Optional information: (for Savon Dental Plan's use in case of extreme emergency)**

What is your Personal Mailing Address? \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Personal Phone Number? (\_\_\_\_) \_\_\_\_\_

**All information in this profile is confidential and remains the property of Savon Professional Services, Inc., and Savon Dental Plan.®  
No information contained herein may be released without the express written permission of the provider listed herein.**