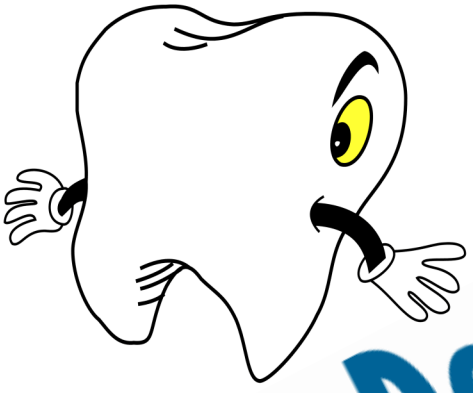


Savon Dental Plan®

America's Dental Plan

Fast Track Specialist And Center Add-on Forms

Covers All Zones For Credentialed Centers Add-on

(602)841-3494 • 1-800-809-3494 • Fax (602) 589-0417

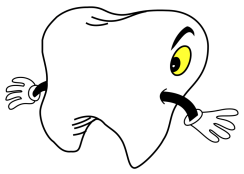
Corporate Office: Phoenix, Arizona

Mailing Address: PO Box 54277, Phoenix, AZ 85078

Website: www.SavonDentalPlan.com

Email: ProviderServices@SavonDentalPlan.com

Savon Dental Plan



Credentialing Check List

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

For each specialist center please submit:

[ ] 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***

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.

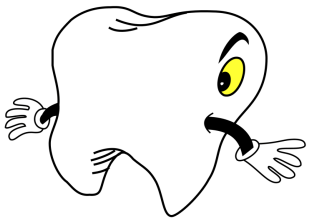
[ ] PROFESSIONAL LIABILITY INSURANCE POLICY NUMBER AND EXPIRATION DATE

[ ] 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 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).

Adress:_____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)

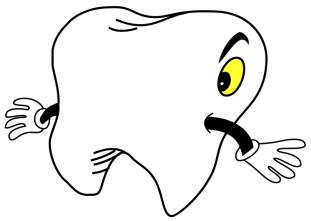
Please Tell Us About Options and Special Equipment that you have

(please check all that apply to your office)

[ ] Nitrous Oxide	[ ] Ultra Sonic Cleaning	[ ] Laser	[ ] Electro Surge
[ ] IV Sedation	[ ] Oral Sedation	[ ] Prophy Jet	[ ] Denta Cam
[ ] K.C.P. 2000	[ ] Brite Smile/Zoom (etc.)	[ ] High Speed Endo	[ ] Digital X-Ray
[ ] Cavitron	[ ] Children Sedation	[ ] On site denture Lab	[ ] On site Crown & Bridge Lab
[ ] Panoramic x-ray	[ ] Diode Laser	[ ] CAD/CAM (Cerec)	[ ] 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

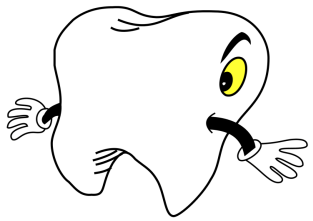
Compliance Procedures

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? (_____)_____

Savon Dental Plan . P.O. Box 54277 . Phoenix, AZ 85078 . (602) 841-3494. (800) 809-3494 . Fax (602) 589-0417 . www.SavonDentalPlan.com