



Eleven Penn Plaza, New York, NY 10001 • 800-647-2677 • E-mail: Director@MediSaver.com

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February 11, 2002

Dear Doctor:

We have patients in your area now! MediSavers is a proven program in the greater metropolitan New York area and is expanding to nationwide scope. MediSavers has been featured in The New York Times, The Wall Street Journal Report, and in over 200 individual newspaper articles, 150 radio reports, and 100 TV stations across the United States.

MediSavers provides for dental, medical, optical and many other services, as well as prescriptions (in accordance with President Bush's plan for affordable healthcare). In an economic recession, consumers tend to defer costly yet vital dental work. MediSavers overcomes this problem. MediSavers members have no limitations and may utilize all of your services including Cosmetic Dentistry.

Our dental program offers our providers:

- **Simple Procedures for Guaranteed Payment within 10 Days from MediSavers**
- **Confidentiality**
- **No Paperwork**
- **No Membership or Application Fees to the Provider**
- **Free Marketing and Advertising**

You can fill idle chair time and thereby increase your revenue at no additional cost. MediSavers will list you on the Internet, in print and media advertising, and inform our Members of your location.

MediSavers requires that you provide free oral examinations; however, you may charge for x-rays as needed. You are also required to provide our Members a discount from your Usual and Customary fees of either 1) 25%

- \*
  - 2) 33 1/3% \*\*
  - 3) 40% \*\*\*
  - 4) Other ? \*\*\*\*\*

Remember that when the member is choosing a dentist, the size of the discount will undoubtedly influence his or her selection. Therefore, the size of the discount you provide will have a direct impact on the volume of MediSavers patients you receive.

**DON'T MISS THIS VALUABLE OPPORTUNITY!** There is no cost to participate. To apply, send in your agreement, including the census form and required documentation, and we'll process them immediately. **Please respond by March 31, 2002 to be included in our next directory.** Call us at 800-647-2677 for more information.

Sincerely,  
**David Konigsberg**  
President

P.S. Our providers say we're their fastest paying program. Twenty of our providers each earned over \$52,000.00 last year, including several who earned over \$100,000.00 as a result of our patient referrals.

# How To Join MediSavers

1. Fill out Census Form.
2. Fill in Dental Provider Agreement (on reverse side of Census Form),  
and indicate the discount amount of 25, 33 1/3, 40% or other  
(greater than 25%).
3. Sign and date the Dental Provider Agreement at bottom.
4. Enclose a copy of the following documents:
  - a. State License or Registration
  - b. Professional liability insurance coverage
  - c. Specialty and/or sub-specialty certification
  - d. DEA certificate
5. Mail completed materials to:

MediSavers  
Attn: Provider Relations  
11 Penn Plaza, Suite 330  
New York, NY 10001

6. If you have any questions please call Provider Relations at 800-647-2677.

## **MediSavers Participating Dental Provider Census Form**

This form must be completed by EACH participating provider, and accompanied by appropriate documentation  
For Employees and Affiliates please photocopy this form BEFORE entering information  
Please TYPE or PRINT complete answers to each item

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## Personal Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Tax I.D. Number \_\_\_\_\_ Social Security Number \_\_\_\_\_ DEA Number \_\_\_\_\_

License #1 \_\_\_\_\_ State \_\_\_\_\_ License #2 \_\_\_\_\_ State \_\_\_\_\_ License #3 \_\_\_\_\_ State \_\_\_\_\_

Dental School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Year Grad \_\_\_\_\_ Specialty \_\_\_\_\_ Board Eligible/Certified \_\_\_\_\_ Date \_\_\_\_\_

Hospital Affiliations \_\_\_\_\_

Malpractice Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_ Policy Limits \_\_\_\_\_ Expiration Date \_\_\_\_\_  
3rd party notification required. Please have your carrier confirm when in effect.

Please list other Managed Care programs in which you participate \_\_\_\_\_

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## Billing Information

Billing Name \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

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## Office Information

Office #1 Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ Contact \_\_\_\_\_

Sunday \_\_\_\_\_ Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday \_\_\_\_\_ Saturday \_\_\_\_\_

Foreign Languages spoken at this office \_\_\_\_\_ E-Mail \_\_\_\_\_

Office #2 Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ Contact \_\_\_\_\_

Sunday \_\_\_\_\_ Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday \_\_\_\_\_ Saturday \_\_\_\_\_

Foreign Languages spoken at this office \_\_\_\_\_ E-Mail \_\_\_\_\_

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Please Mail Completed Form and required documentation to: MediSavers, Attn: Provider Relations, 11  
Penn Plaza, Suite 330,  
New York, NY 10001

# Practice Information

Yes \_\_\_\_\_ No \_\_\_\_\_      Yes \_\_\_\_\_ No \_\_\_\_\_      Other Patient Care Staff \_\_\_\_\_  
Hygienist                      Technician

Average Wait Time for:      First Appointment      Follow up Visit      Waiting Room

Yes \_\_\_\_\_ No \_\_\_\_\_ Type: \_\_\_\_\_      Yes \_\_\_\_\_ No \_\_\_\_\_ Type: \_\_\_\_\_  
Do you provide Anesthesia?      Do you provide Analgesia?

Yes \_\_\_\_\_ No \_\_\_\_\_      Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you accept per capita payment?      Would you consider per capita payment?

If other dentists are affiliated, write names and complete a census form for each

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If other dentists are employed, write names and complete a census form for each

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*(Please use the space at the bottom of the page or a second sheet for explanations or comments)*

Do you now have, or have you ever had, any malpractice cases or lawsuits filed against you? \_\_\_\_\_

Have you ever been disciplined by a State board? \_\_\_\_\_

Has your license ever been suspended or revoked? \_\_\_\_\_

Have you ever been refused participation in or asked to leave a Managed Care plan? \_\_\_\_\_

Number of years of practice in the United States: \_\_\_\_\_

Hours of continuing education in the last 2 years: \_\_\_\_\_

Number of years that you have been in practice: \_\_\_\_\_

*Please use this space for awards, honors, memberships or publications, and/or explanations from above:*

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We MUST BE INFORMED of any change in the above information, including change in malpractice carrier or liability limits. You MUST send copies of appropriate documentation, including, but not limited to, license, board certification or eligibility, and proof of malpractice coverage. Current and/or pending malpractice suits should be accompanied by appropriate explanations. The MediSavers Participating Provider Network is open to ALL providers who meet its selection criteria and are willing to abide by its rules, regardless of race, creed, color, religion or national origin. Providers agree to treat all patients equally without regard to race, creed, color, religion, national origin or source of payment.

For Additional Information Call Provider Relations: 800-647-2677

Fax: 212-629-0749 • E-mail: Director@Medisaver.com

DENTAL PROVIDER AGREEMENT

This agreement, between MEDISAVERS, and \_\_\_\_\_ ("Provider") sets forth the rights and responsibilities of the parties hereto.

Relationship

MEDISAVERS is a Preferred Provider Organization (PPO), providing access to participating providers to its enrolled membership.

The Provider is duly licensed and qualified to practice dentistry in the state(s) of \_\_\_\_\_.

MEDISAVERS and the Provider desire that the Provider become a member of the MediSavers Participating Provider Program for the purpose of providing professional care and treatment to eligible members and dependents of groups serviced by MEDISAVERS. Provider enters into this agreement as an independent contractor and no employer/employee relationship exists or is intended. Provider will at all times maintain the Provider/patient relationship and will be solely responsible for determining and administering the care and treatment of the patient.

Rights and Responsibilities

Both MEDISAVERS and the Provider will be bound by the procedures and requirements herein. These procedures and requirements will remain in effect during the term of this agreement, unless modified in writing, signed by both parties.

The attached census form completed by the Provider is made part of this agreement, and the Provider warrants that all information contained therein is true and complete, and recognizes that MEDISAVERS enters into this agreement in reliance thereon. The Provider will promptly advise MEDISAVERS upon material change in any information which is contained in the census form.

Reimbursement

All reimbursement for services rendered by the Provider under this agreement will be on a fee for service basis, with a discount of:

- 25%
- 33 1/3%
- 40%
- Other (greater than 25%) \_\_\_\_\_%

off the provider's usual and customary charges. The discount provided by the Provider to MEDISAVERS will be no less than the discount granted to any other entity or organization.

Fees

The Provider does not pay any fees or dues for participating in this program.

Billing and Payment

Billing and payment will be governed by the rules and guidelines herein. These rules and guidelines will remain in effect during the term of this agreement, unless modified in writing.

Term

This association is purely voluntary, and may be terminated without cause by either party upon ninety (90) days written notice to the other party. The Provider will complete all work and plans of treatment in progress.

\_\_\_\_\_  
Provider

Date\_\_\_\_\_

\_\_\_\_\_  
MediSavers

Date\_\_\_\_\_

## Procedures and Requirements

1. Patients will be referred by MEDISAVERS directly to the Provider, either by a staff member or MEDISAVERS' computerized provider locator system.
2. Should a referral to any other Provider be required, the Provider or patient **must** call MEDISAVERS and specify the type of specialist/Provider required. MEDISAVERS will furnish the patient with a participating Provider. The Provider is **not** to refer the patient directly to another specialist/Provider. If the Provider does so, the Provider will be responsible for ensuring that MEDISAVERS, the patient, the member, and the member's sponsoring group have no more expense than would have been incurred had a participating Provider been used.

## Billing and Payment

1. All fees for services covered by this agreement will be paid by MEDISAVERS', using the clients' monies, directly to the Provider. The Provider understands and agrees that under whatever method or manner he receives payment, payment is not made with MEDISAVERS' own funds, but with funds supplied to it by MEDISAVERS' clients. The Provider understands and agrees that MEDISAVERS is neither a guarantor nor insurer of payment to the Provider and that the Provider must ultimately seek payment from the patient. All disputes wherein claims payments may be withheld must be resolved by the Provider and the patient. If payment is not made by MEDISAVERS and is then sought by the Provider from the patient, the Provider shall be entitled to a fee based upon his/her usual and customary charges from the patient. The Provider will neither seek nor accept payment from the eligible patient or member for any covered service. MEDISAVERS is NOT an insurance company.
2. There is usually no co-payment or cost sharing for covered services rendered to eligible members and dependents of groups participating in MEDISAVERS'. The agreed upon fees will be accepted in full payment by the Provider. If a co-payment is in effect, it will be so indicated on the participant's identification card. If no co-payment is indicated, the Provider will not ask the participant for money. If a co-payment is indicated, the Provider will accept only that amount from the participant.
3. The Provider will file claims electronically, AFTER services have been rendered, via an ordinary touch-tone telephone, follow the computer prompts and enter the information accurately. The system will return an authorization code if the patient is eligible and covered for the services rendered. Payment will be made within ten (10) business days. The Provider must provide the patient with a statement showing the services rendered and the usual and customary fees filed electronically. [It is recommended (but not required) that the Provider submit the claim while the patient is still present in the office.] In the event that a claim is rejected, the Provider may charge the patient at his/her usual and customary fee for services rendered. The Provider may file a paper claim, but there will be no guarantee of payment.
4. In cases where there is other coverage, and that coverage is primary, the Provider **must** bill the other coverage first. If the other coverage pays less than the amount provided under this agreement, then the Provider will be paid the difference between the amount paid by the other coverage and the amount provided under this agreement. Documentation of the first coverage's payment must be submitted to MEDISAVERS along with the claim for co-coordinated benefit payment.
5. In cases where there is other coverage, and that coverage is secondary, MEDISAVERS will pay the amount allowed under this agreement. The Provider may then seek the balance of his/her usual and customary charges from the Provider of the other coverage.