DELTA DENTAL

HDS
Hawaii Dental Service

Adding a Treating Location

(For dentist currently participating with HDS that need to register an additional treating location)

To add a new treating location please complete, sign and return the following:

- ☐ Payment Information and Treatment Location Form
- ☐ IRS Form W9
- ☐ Provider Portal Authorized Agent Form
- ☐ Participating Dentist Directory Form
- ☐ Direct Deposit Form.This is optional if you are joining a business previously registered with HDS as you will inherit their payment information including any direct deposit banking information.
- ☐ If the provider is already a Medicare Advantage (MA) and/or a Supplemental Medicaid (SM) provider, and will treat MA/SM patients at this location, you must register this location as a MA/SM location. Please complete the MEDICARE ADVANTAGE & SUPPLEMENTAL MEDICAID NETWORK(S) MAINTENANCE FORM (last two pages).

If any of the items below apply, please address accordingly:

- If you are using a new Tax Identification Number call the IRS Customer Service Department at 800-829-0115 or 800-829-4933 to obtain and submit a copy of the IRS Form SS-4 or 147C.
- If you are purchasing an existing practice, you or the seller may need to complete additional forms. Call Professional Relations.
- If you no longer work at a previous business or treating location, you must complete the "Inactivate Provider Form." Call Professional Relations.

In order to avoid processing delays, please complete, sign and return all required documents. Incomplete forms will not be processed and will be returned to you.

Why Register?

- Dentists must accurately report the address where treatment is being rendered on all dental claim submissions.
- Registration avoids processing delays.
- Free publicity! Service location(s) appear on our public website where patients may search for a participating dentist by name, city, zip code, island or specialty.
- HDS will update the National Provider File for Delta Dental claim processing.

Once registration has been completed, HDS will provide a filing number (to be used for paper claim filing) for each location. For HDS Online claim submission, select the appropriate filing number or treating address prior to submitting your claim.

If you have any questions or need assistance, please call Professional Relations. We are here to help!

Phone: 529-9222 or toll-free 844-379-4324

E-Fax: 808-529-9223
Email to: HDSProfessionalRelations@HawaiiDentalService.com

Professional Relations Department
808-529-9222; Toll-free 844-379-4324
Fax 808-529-9223
HDSProfessionalRelations@HawaiiDentalService.com

Reset Form

Payment and Treatment Location Information

ASSIGNMENT OF PAYMENTS (Include IRS Form W9)

Select the reason for this submission:
- ☐ Part of a membership application
- ☐ Changing an existing payee/TIN
- ☐ Updating a payee name or address
- ☐ Adding a new dentist, business or treatment location.

Effective date:	Is this form being submitted due to the sale or purchase of an existing dental practice? ☐ YES ☐ NO

I hereby authorize Hawaii Dental Service to direct my payments to:

Payee Information

Name (as shown on your income tax return).

Business name, if different from above

Taxpayer Identification Number (Include Form W9)
- ☐ Social security number:
- OR
- ☐ Employer identification number: _____

Mailing Address

Payment mailing address

City | State | Zip

Payee information indicated above applies to the treatment location listed below (and/or attached):

Treatment Location

Treatment Location Address #1

Address line 2

City | State | Zip

Phone Number	Fax Number	NPI TYPE 2 (Organizational)

Treatment Location

Treatment Location Address #2

Address line 2

City | State | Zip

Phone Number	Fax Number	NPI TYPE 2 (Organizational)

Need to add more locations? Attach a listing of all treatment locations covered by this payee/TIN.
If payees differ by treating location, a separate Payment and Treatment Location Information form is required for each new payee. Contact Professional Relations for more information.

I attest that the information above is true, complete, and accurate to the best of my knowledge and belief. I have signed this form electronically and agree that the electronic signature appearing on this document is the same as my handwritten signature for purposes of validity, enforceability, and admissibility.

Dentist Signature	**Date**
Dentist Name (please print)	**License Number**

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

HDSProfessionalRelations@HawaiiDentalService.com
Phone 529-9222 or toll free 1-844-379-4324
Fax 808-529-9223

CLAIM SUBMISSION AND PROVIDER PORTAL AUTHORIZED AGENT FORM

SECTION A. PROVIDER AND PRACTICE INFORMATION; CERTIFICATION & ACKNOWLEDGMENTS			
Dentist Last Name	First Name	License No.	Email Address
Legal Business Name		TIN	Phone Number
Treatment Address (attach a list of additional treating locations if necessary)			

CERTIFICATION & ACKNOWLEDGMENTS:

I hereby certify that the individuals listed in Section B ("Authorized Agents") are authorized:

(i) to execute, on my behalf and as my duly authorized agent(s), all claims and related transactions for services rendered.

(ii) to access the HDS online provider portal ("Provider Portal") and interactive voice response systems to conduct claims and administrative activities on behalf of me and my dental practice.

If I treat patients at a practice to which I have assigned my payments, I agree that any Authorized Agents designated by that practice shall also be my Authorized Agents.

I agree that this form will keep my signature on file for claim submissions (paper and electronic).

I certify that I maintain the patient's signature on file for submission of all claims sent to HDS and release of all information related thereto. I agree to accept full responsibility for the accuracy and propriety of each submitted transaction and understand that the execution of each submission shall constitute a certification that the charges indicated are proper and correct and that no payments have been received except as noted.

I agree that the appointment of the Authorized Agents listed in Section B shall remain in effect, and may be conclusively relied upon by HDS, until HDS receives a verbal or written cancellation either by me or my Authorized Agent(s), which shall be done promptly, but no later than one (1) business day, following the termination of the authority of any Authorized Agent listed. I understand and agree that I must execute and submit an updated copy of this form if I want to add additional Authorized Agents.

I certify that I and my Authorized Agents agree to comply with all rules and regulations concerning the privacy and security of protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when submitting claims and accessing the Provider Portal.

I understand that for security purposes HDS may monitor the IP addresses from which my Authorized Agents access HDS systems including the Provider Portal and may send email notifications from time to time regarding access activity. I acknowledge and agree that HDS may modify, revoke, or terminate access to HDS systems at any time for any reason or no reason, in its sole discretion and without notice.

RELEASE AND INDEMNIFICATION: I hereby release and indemnify HDS against any claims, lawsuits, or allegations arising from or in connection with: (i) inaccurate or improper claims submitted by me or my Authorization Agents, (ii) improper access or use of any HDS system by me or my Authorized Agents or any person or entity using my Authorized Agent's access credentials, and (iii) any violation of law, including HIPAA requirements, state or local privacy or data breach laws, or the rights of a third party.

Dentist Signature _____ Date _____

Dentist Name (please print) _____

HDSProfessionalRelations@HawaiiDentalService.com
Phone 529-222 or toll free 1-844-379-4324
E-Fax 808-529-9223

SECTION B. AUTHORIZED AGENTS (Please use a second page if needed)

1) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information	HDS Use Only User ID:
2) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information	HDS Use Only User ID:
3) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information	HDS Use Only User ID:
4) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information	HDS Use Only User ID:
5) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information	HDS Use Only User ID:
6) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information	HDS Use Only User ID:
7) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information	HDS Use Only User ID:

Professional Relations Department
808-529-9222; toll-free 844-379-4324
Fax 808-529-9223
HDSProfessionalRelations@HawaiiDentalService.com

Participating Dentist Directory Form

Complete this form to update your practice information.
This form is not to be used to change demographic information.
*indicates that this information may be displayed to the public on HDS and Delta Dental websites.
Questions related to Accessibility Information will default "NO" if left unanswered.

Dentist Name*	License No.
Business Name	Tax Identifier No.
Treatment Address this form applies to*	Phone*

If you work at multiple treating locations would you like HDS to use the information below for all locations associated with this business? ☐ Yes ☐ No

Email and Website Information

Website*	Personal Email (this will be kept private and used for HDS correspondence only).

Office Email*
☐ Display it to the public*
☐ Do not display it (for HDS correspondence only)

Accessibility Information*

Are you accepting new patients?	☐ Yes ☐ No
Is your office accessible by public transportation?	☐ Yes ☐ No
Is your office wheelchair accessible?	☐ Yes ☐ No
Do you treat children with physical disabilities?	☐ Yes ☐ No
Do you treat adults with physical disabilities?	☐ Yes ☐ No
Do you treat children with intellectual disabilities?	☐ Yes ☐ No
Do you treat adults with intellectual disabilities?	☐ Yes ☐ No
Do you treat children under the age of one year old?	☐ Yes ☐ No
Do you provide amalgam restorations?	☐ Yes ☐ No

Please indicate any special hours of operation
☐ Early Mornings (before 8 A.M.)
☐ Evenings (after 5 P.M.)
☐ Weekends

Languages Spoken in Office*

Besides English, what other languages are spoken in this office?	Proficient in American Sign Language?
Tagalog Ilocano Cantonese Mandarin Japanese Korean Chuukese Samoan Spanish Other _____	☐ Yes ☐ No

Claim Submission and Office Contact Information

Do you submit claims electronically using a clearing house or practice management software? ☐ Yes ☐ No	Name of clearinghouse and/or software

Office Manager Name	Phone	Email

This form applies to:
- ☐ HDS payments
- ☐ Medicaid payments
- ☐ Delta Dental payments

HAWAII DENTAL SERVICE
Professional Relations Department
E-Fax 808-529-9223
HDSProfessionalRelations@HawaiiDentalService.com

DIRECT DEPOSIT ENROLLMENT

PAYEE INFORMATION

Complete legal name of institution, corporate entity, practice or individual provider:

_____

PROVIDER IDENTIFIER INFORMATION

_____ _____

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

National Provider Identifier (NPI)

PROVIDER AGENT INFORMATION

Name of Provider's Authorized Agent(Authorized to add/change/cancel EFT enrollments):

_____

Name of a contact in agent office for handling EFT issues: _____

Telephone Number: _____ Email Address: _____

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name: _____

Financial Institution Routing Number: _____

Type of Account at Financial Institution: ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution: _____

Provider payments will be grouped by the TIN/EIN listed on this form.

SUBMISSION INFORMATION

Reason for Submission

Check one: ☐ New Enrollment ☐ Change Enrollment

Include with Enrollment Submission (see sample forms on back)
☐ Voided check or ☐ Bank Letter (a Letter on bank letterhead that formally certifies the account owners routing and account numbers)

I hereby authorize Hawaii Dental Service (HDS) to initiate direct deposits of my claim payments to the account indicated above. I agree that HDS shall be entitled to rely upon this authorization in making all claim payments owed to me by direct deposits into the above account. Each such deposit shall constitute payment in full of the amount so deposited and shall fully satisfy HDS's obligation to pay that amount to me.

_____ _____ _____

Dentist/Authorized Agent's Signature | Printed Name | Date

HDS REMITTANCE ADVICE OPTIONS

HDS Remittance Advice Information can be obtained by one of the following methods:
- Download your Remittance Advice at www.hdsdentistportal.org or www.hdsmedicaid.org
- Request a Fax via DenTel (545-7711 or 800-272-7204).

DELTA DENTAL DIRECT DEPOSIT – OPTION

To sign up for Direct Deposit with Delta Dental on a National level, read and sign in the box below.

Opting in for Delta Dental Direct Deposit:

By signing below, you hereby acknowledge and agree that (i) all information you provided above may be shared with any entity that is an affiliate of Delta Dental, with other Delta Dental member companies and their affiliates, and with Delta Dental Plans Association for use in connection with funds to be deposited to your account, (ii) an election to discontinue enrollment in this direct deposit program may take up to 14 business days to process and will not halt any deposits that were initiated while your enrollment in this direct deposit program was still in effect, *and (iii) in the absence of gross negligence or willful misconduct, neither we, any of our members and affiliates, other Delta Dental member companies and their affiliates, nor Delta Dental Plans Association, will be responsible for any damages, or for any fee, charge or other expense assessed against the Bank Account identified above, in connection with this direct deposit program.*

Further, by signing below, you represent and warrant that (i) all of the information you supplied is true and accurate, (ii) the information provided under the heading "Financial Institution Information" above, identifies a bank account held by the Business you identified above, and (iii) the signatory to this Direct Deposit Enrollment Form ("Form") has all necessary power and authority to execute this Form.

Dentist/Authorized Agent's Signature	Printed Name	Date

DELTA DENTAL REMITTANCE ADVICE:

National Delta Dental Electronic Remittance Advice (ERA) information can be found at www.DeltaDental.com.
Got to www.DeltaDental.com to create an account and check your National ERA.

Need help creating an account or viewing your ERAs? Call HDS Professional Relations at 808-529-9222 or toll free 844-379-4324 for assistance.

Please return the completed form with your voided check or bank statement by email or

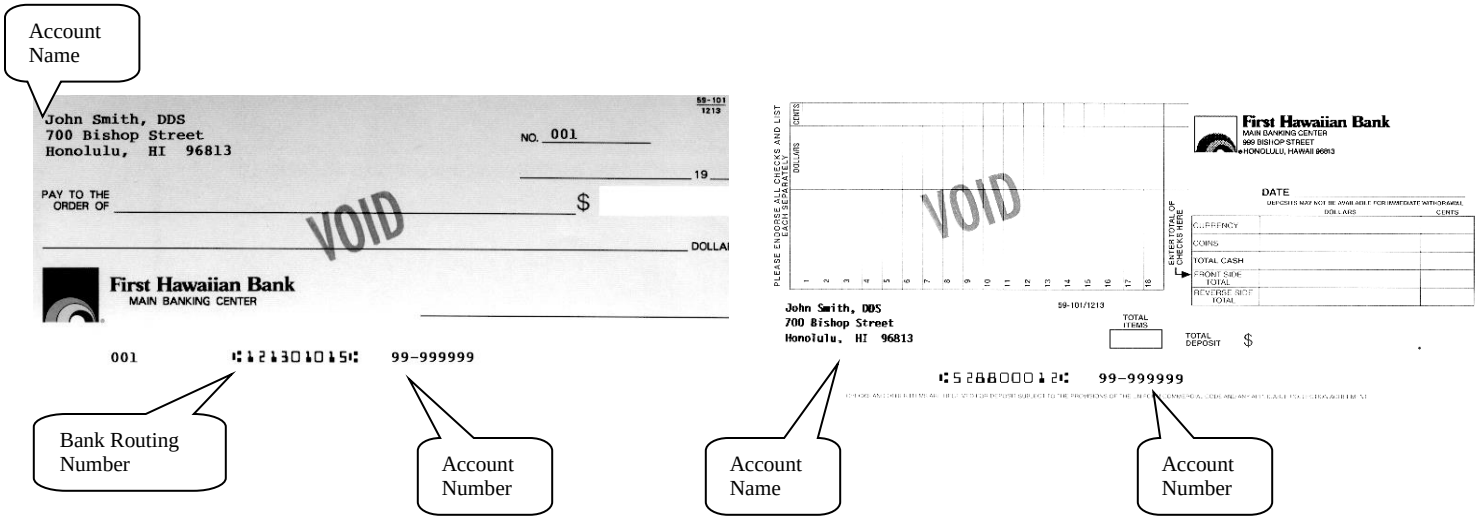
Fax to HDS Professional Relations:

Email: HDSProfessionalRelations@HawaiiDentalService.com

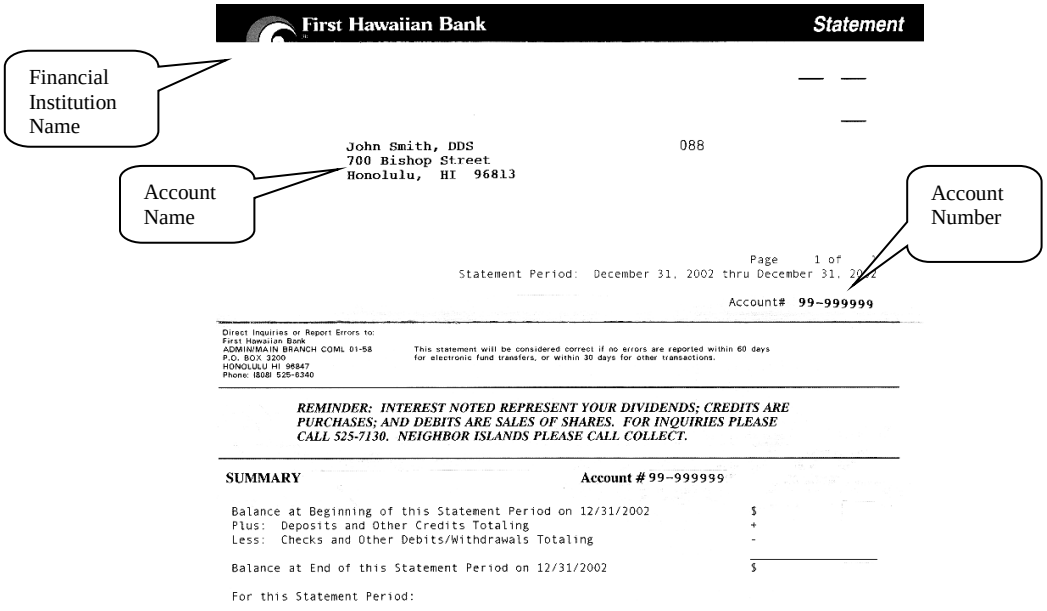
E-Fax: 808-529-9223

***SAMPLE FORMS ***

- **For checking accounts,** submit either a voided check or deposit slip.



- **For saving accounts, submit a copy of the monthly statement.**



This form is for use by providers that are currently enrolled as Medicare Advantage and/or Supplemental Medicaid.

Professional Relations Department
808-529-9222; Toll-free 844-379-4324
Fax 808-529-9223
HDSProfessionalRelations@HawaiiDentalService.com

DELTA DENTAL
HDS
Hawaii Dental Service

HDS MEDICARE ADVANTAGE & SUPPLEMENTAL MEDICAID NETWORK(S) MAINTENANCE FORM

SELECT WHICH NETWORKS THIS FORM APPLIES TO:

_____ Medicare Advantage Network

Have you "Opted Out" of Medicare with the Centers for Medicare and Medicaid services?
_____ YES _____ NO

_____ Supplemental Medicaid Network

PROVIDER INFORMATION

Last Name	First Name	MI	HI License No.

BUSINESS AND SERVICE OFFICE INFORMATION

HDS will only pay claims for services rendered to registered business entities and service office locations registered using these forms.

Be sure to list the type of patient you will treat at each service address (next page) for any network you have joined and are registering.

Please do not list service locations and or/entities where you will not treat these types of patients.

Do you work for more than one business entities (different Tax Identification Numbers) where you will be treating Medicare Advantage/Supplemental Medicaid patients that you want to register now?

_____ YES _____ NO

If YES, please submit a separate form for each individual Tax ID / Business Entity you would like to register.

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DELTA DENTAL

HDS Hawaii Dental Service

HDS MEDICARE ADVANTAGE & SUPPLEMENTAL MEDICAID NETWORKS

PAYEE/BUSINESS ENTITY INFORMATION	
TAX ID Number (required)	Name (as shown on your income tax return) (required)
Are you the business owner?	_____ YES _____ NO If no, please list the business owner's names below in the space provided. If there are no Owners, please list all Members If applicable.
Are you the sole business owner?	_____ YES _____ NO If no, please list the business owner's names below in the space provided. If there are no Owners, please list all the Members if applicable.

BUSINESS OWNERS/MEMBERS	
First Name	Last Name
First Name	Last Name
First Name	Last Name
First Name	Last Name
First Name	Last Name
First Name	Last Name

TREATMENT LOCATION INFORMATION

List the treatment service locations and the type of network patients you will be treating under this single entity. Attach a list of additional locations as needed.

Treatment Location Address			Type of patient(s) you will treat at this location:
Address line 2			_____ Medicare Adv. _____ Supp. Medicaid
City	State	Zip	
Treatment Location Address			Type of patient(s) you will treat at this location:
Address line 2			_____ Medicare Adv. _____ Supp. Medicaid
City	State	Zip	

Attestation

I attest that the information submitted with this form is complete, and accurate to the best of my knowledge and belief. I have signed this form electronically and agree that the electronic signature appearing on this document is the same as my handwritten signature for purposes of validity, enforceability, and admissibility.

Dentist Signature: Date: