

Lifelong.

Lifelong Dental Program · 4634 E Marginal Way S Suite C 200 · Seattle, WA · 98134 · P. 206-957-1715 · F. 206-960-4847

Lifelong Dental Program Provider Manual

LIFELONG DENTAL PROGRAM: PROVIDER MANUAL

The Lifelong Dental Program (LDP) is a comprehensive oral health access program whose aim is to support low-income HIV-positive individuals living in King, Snohomish, and Island counties to access oral health care services. The program covers the costs of dental procedures that are deemed ***medically necessary*** and ***time-sensitive*** by participating dental providers and clinics.

Program funds can be used to treat Phase I – Urgent/Diagnostic, Phase II – Disease Control (only when imminent), Phase III – Restorative, and Phase IV – Maintenance dental procedures as identified per the appended LDP Dental Fee Schedule.

This manual describes the procedures participating dentists must follow for reimbursement of services rendered to eligible clients.

HOW TO ENROLL AS A PROVIDER

To become a contracted, participating dental provider of LDP, dental providers must submit the required documents to the LDP Program Manager, signifying an agreement to accept the terms outlined in this manual.

The following is a summary of all materials that must be submitted to the LDP Program Manager to enroll as an LDP dental provider:

- Memorandum of Understanding (Appendix A)
 - License numbers and Taxpayer Identification Number (TIN)/Social Security Number (SSN) are needed to establish a vendor code for payment purposes only.
 - A Unique Entity Identifier (UEI) is also required.
- A list of all participating dentists and copies of their dental licenses
- A list of all the dental insurance carriers your office accepts or provide instructions on where to locate this information (e.g., clinic website)
- Public Health – Seattle & King County Substitute W-9 form (Appendix B) – ***For new dental providers/clinics only.***

The LDP Program Manager will submit the received documents to Public Health – Seattle & King County (PHSKC), and PHSKC will develop a contract with the dental provider. Completed contracts will be forwarded to the dental provider for review and signature. A signed copy of the contract must be returned to PHSKC along with proof of liability and professional insurance coverage (see example in Appendix E). Once the contract is finalized and signed by all necessary parties, the LDP Program Manager will contact the dental provider to review LDP processes. The LDP Dental Coordinators will work with clients and dental provider/dental office staff to set up client appointments (see

APPOINTING below). *Initial appointments at a dental provider must be made through LDP to ensure reimbursement for services provided.*

Annual Provider Contract Awards:

The LDP Program Manager and dental provider will negotiate contract amounts based on factors such as the number of clients the provider can serve, provider specializations, location, and other considerations. This **set** award amount is the total funding available for the provider to use toward the oral health needs of LDP clients during the contract year (March – February).

Providers are fully responsible for tracking their spending and ensuring they do not exceed their total contract award. This includes **monitoring scheduled appointments and projecting future spending** to stay within budget. **LDP will not reimburse any spending beyond the awarded contract amount. Any overages must be written off by the provider, and billing LDP clients for these services is strictly prohibited.**

To support spending oversight, the LDP Program Manager will send monthly provider spending reports and client expenditures. Additionally, at the midpoint of the contract period, providers **must** report their remaining funds and indicate whether they anticipate: Fully utilizing their award, Underspending and having remaining funds, Spending ahead of schedule and exhausting funds early

If a provider anticipates **underspending**, they must provide an estimate of the remaining funds so the LDP Program Manager can collaborate with PHSKC on reallocation.

If a provider spends out early, they must immediately stop scheduling new or ongoing client appointments and notify the LDP Program Manager within ten business days. The LDP Program Manager will assess whether additional funds can be allocated, but **there is no guarantee of additional funding.**

Client Eligibility

Client eligibility is processed by the Department of Health's Early Intervention Program (EIP) and must be renewed annually. Lifelong's Program Referral and Enrollment (PRE) team processes referrals received for LDP and forwards them to LDP when they are ready. LDP can assist clients in applying for or renewing eligibility. To be eligible for LDP, clients must:

- Be a resident of King, Island, or Snohomish County
- Be HIV Positive
- Have an income below 500% Federal Poverty Level

A client eligibility report will be faxed or sent through encrypted email by LDP on the last business day of the month to dental providers/dental offices, notifying dental providers of all clients who have been ended or renewed in that month. *The dental providers are responsible for monitoring client eligibility dates using the initial appointing sheet, the monthly client eligibility reports, and corresponding with LDP Coordinators as needed. LDP will NOT be able to reimburse dental providers for services provided to clients who were not eligible for LDP at the time of service.*

Any questions about client eligibility should be submitted to LDP. The LDP team can be reached at (206) 957-1710 or by email at Dental@lifelong.org.

Annual Maximum Spending per Client:

The maximum annual spending allowed per client is **\$3,000 per contract year (March – February)**. If a dental provider determines that treatment beyond a client's maximum is medically necessary, the provider must submit a treatment plan and the **Treatment Plan Over \$3,000 Request Form (Appendix D)** to request pre-authorization. This pre-authorization request to spend over the client annual \$3000 maximum amount allowed **MUST** be submitted in writing to the LDP Program Manager **before** performing any medically necessary work. The LDP Program Manager will review and approve treatment above the annual maximum based on medical necessity while ensuring that costs remain within the provider's total annual contract award. these cases will be established on a case-by-case basis.

Providers are fully responsible for monitoring each client's spending to ensure they do not exceed the allocated annual maximum. LDP will not cover any costs exceeding the client's limit, and providers will be required to

write off any overages. Under no circumstances may providers bill LDP clients for services exceeding the approved funding.

Additionally, providers must strategically plan treatment schedules to distribute care across multiple contract periods as needed. **It is the provider's responsibility to ensure that treatments are spaced appropriately to align with available funding.** Failure to do so may result in **denial of reimbursement** for services that exceed the approved limits.

APPOINTING

The LDP Coordinators and the PRE team at Lifelong will confirm initial client eligibility through a referral process. Once eligibility is confirmed, the LDP Coordinators will help clients schedule their first dental appointment:

- The LDP Coordinator will call the dental provider/dental office and work to schedule an initial appointment with the client on the line.
- When the appointment is scheduled, the LDP Coordinator will send the dental provider/dental office a confirmation fax containing the client's LDP eligibility dates and appointment information. The receipt of this fax indicates that the client is fully enrolled in LDP.

Clients may schedule all future appointments directly with the dental provider.

Specialist Referrals:

If the dental provider determines that an LDP client needs treatment from a specialist, the provider must complete the LDP Specialist Referral Form (Appendix G and F) and fax it to LDP at (206) 960-4847. Once the form is received, LDP will connect the client to a contracted LDP specialist. Dental providers should not refer clients directly to specialists as this could result in clients being seen by non-contracted LDP providers.

SCOPE OF SERVICES AND REIMBURSEMENT

The scope of services and the reimbursement rate for the oral health program is based on the dental fee schedule established specifically for LDP. The LDP Dental Fee Schedule lists allowable services and fees.

LDP will exclusively reimburse for treatments and services specified on the LDP Dental Fee Schedule, provided they are deemed medically necessary. It's crucial to highlight that certain dental procedures listed on the LDP Dental Fee Schedule necessitate pre-authorization from the LDP Program Manager.

These pre-authorizations must be submitted in writing and must clearly indicate the medical necessity for the proposed procedures. Such procedures must be approved before the service is rendered; otherwise, reimbursement may be declined. *Dental providers/dental offices may not charge clients any copays for services paid through the LDP.*

If a dental provider recommends medically necessary treatment to a client that is not included in the LDP Dental Fee Schedule, the dental provider must be certain the client is aware of the out-of-pocket costs that will be required of them. The dental provider should also notify the LDP Program Manager of this treatment recommendation and costs.

LDP funds can be used for procedures disallowed by other third-party payers (e.g., Medicaid) but are allowed by the LDP Dental Fee Schedule. Furthermore, LDP funds may be used to assist clients with private insurance for out-of-pocket costs up to the LDP Dental Fee Schedule amount for a given procedure. This does not apply to Medicaid. **Payment by Medicaid for dental services must be accepted as payment in full.**

Claim Form Submission:

Dental claim forms may be submitted by US mail, fax, or encrypted email. All claims must be submitted to LDP on a standard dental claim form (Appendix C) within ten business days of the completed treatment. **Payment may be delayed if claim forms are not sent in a timely manner. Claims submitted more than 90 days after the date of service will be denied.**

Please submit claims through one of the following methods: Mailing Address:

Lifelong Dental Program
4634 E Marginal Way S Suite C200
Seattle, WA 98134
Email Address: Dental@lifelong.org
Fax: (206) 960-4847

Claim Approval:

LDP will approve and process claims within ten business days of receipt. Approved claims are paid by PHSKC. PHSKC will remit payment within 30 days of receiving approved claims from LDP. For clients with private insurance, an explanation of benefits (EOB) MUST be submitted with the claims. Balance billing and/or client co-payments are not allowed. **Fees paid are considered payment in full.**

An electronic explanation of payment will be emailed to the dental provider/dental office once the payment has been sent. This email will be sent by PHSKC to the point person indicated by the dental provider and the LDP Program Manager and will be titled "LDP Reconciliation Documentation."

Payment Discrepancies:

Upon payment being disbursed to the dental provider, PHSKC will electronically send an explanation of payment titled "LDP Reconciliation Documentation" to both the dental provider and the LDP Program Manager. The dental provider is required to reconcile the received LDP Reconciliation Document within 30 days of receipt. In the event of an overpayment, the dental provider must reimburse PHSKC within ten business days of noticing or being notified of the overpayment. Alternatively, if the dental provider identifies an underpayment, they must promptly notify the LDP Program Manager within 30 days of receiving the LDP Reconciliation Document. Subsequently, the LDP Program Manager will review the claim(s) in which the discrepancy was identified and, based on the findings, collaborate with PHSKC to issue a payment adjustment to the dental provider.

Insurance Explanation of Benefits:

Before claims are submitted to LDP for reimbursement, dental providers MUST seek reimbursement from all other third-party payers (e.g., private insurance carriers). Once an EOB has been received for a client AND an LDP dental procedure has been denied or only partially covered, a dental claim form, along with the EOB, should be submitted immediately to LDP for processing. *EOBs received after 60 days of service delivery cannot be*

reimbursed. Exceptions to this 60-day deadline will be considered on a case-by-case basis. Procedures on the LDP Dental Fee Schedule will only be reimbursed up to the amount listed.

LDP calculates the payment for dental services by subtracting the insurance payment from the LDP Dental Fee Schedule rate. After calculating the potential LDP payment, LDP compares it to the client's responsibility amount on the EOB. Then, LDP pays the lesser amount between the two.

REPORTING REQUIREMENTS

Treatment Plans:

The dental service provider is required to establish a treatment plan for the client within 30 days from their initial appointment. This treatment plan should be retained at the dental provider's office and must be accessible within ten business days upon the request of LDP staff.

Not Accepting New LDP Clients:

It is imperative for dental providers to promptly notify LDP staff when their dental office can no longer accommodate new LDP client appointments due to funding constraints. While the LDP Program Manager sends monthly spending reports to dental providers, processing times for claims may result in discrepancies. Therefore, it is essential for providers to diligently monitor their spending and promptly inform LDP when they are unable to accept new LDP clients.

Phase 1 Treatment Plan Completion:

Phase I Treatment Plan completion rates must be reported to LDP. This can be reported on an ongoing basis on claim forms using the code "0000" or "TPCY/N" (treatment plan complete yes OR treatment plan complete no). If these codes are problematic, the dental provider may work with the LDP Program Manager to determine the best reporting methodology for the dental provider. Phase I Treatment Plan completion is to be reassessed for each client on an ongoing basis. Clients are always assumed to be in Phase I Treatment until otherwise reported.

Phase I Treatment is the diagnosis, prevention, and elimination of dental disease. This definition focuses on disease control (restorative, extractions, and hygiene) and excludes crowns, partials, and dentures. Phase I Treatment is complete when the disease is controlled (e.g., clients have had the necessary restorative, extraction, and hygiene treatment).

- Phase I Treatment
 - o Definition: Phase I treatment includes urgent and diagnostic treatment. Caries control, periodontal therapy or prophylaxis, extractions, and some endodontic care.
 - Does not include extensive EXT/RCT. Does not include a removable crown and bridge.

List of Accepted Dental Insurance Carriers:

LDP requires each dental provider to submit a list of accepted dental insurance carriers. If the list changes, an updated list must be submitted within ten business days.

List of Dentists:

LDP requires that each dental office submit a list of their dentists with a copy of their current dental license. If a dentist leaves during the contract year or a new dentist joins the practice, LDP must be informed within ten business days, and a copy of a current dental license for the new dentist must be submitted.

IMPORTANT INFORMATION REGARDING CLIENT CONFIDENTIALITY

LDP is for clients who are HIV positive. Per the Health Insurance Portability and Accountability Act (HIPAA), the confidentiality of HIV status must be maintained in a dental setting. If you do not have a specific policy or procedure in your office to guarantee the confidentiality of the HIV and/or other medical information of LDP clients, one must be developed to be a contracting dental provider. Please keep in mind that written informed consent by the clients is necessary before releasing any information relative to their status. This includes submitting dental claim forms for reimbursement through LDP. We obtain the client's approval to contact you for appointing and billing purposes once they are enrolled in LDP.

Dental claim forms must be completed and submitted confidentially, and the forms must not indicate or imply the client's HIV status. These forms should be handled with discretion to protect the client's privacy. All documents will be treated in a strictly confidential manner in our office.

For more guidance on HIPAA's Privacy Rule or the Security Rule, go to <https://www.hhs.gov/hipaa/>.

Emails with client information MUST be sent via encryption.

All mailed correspondence should be sent to:

All Lifelong Dental Program
4634 E Marginal Way S Suite C200
Seattle, WA 98134

Contact with the dental provider/dental office about clients will be conducted through phone, fax, encrypted email, and US mail to ensure confidentiality. Emails with protected health information (PHI) are not allowed unless sent using encryption.

Appendix A: Lifelong Dental Program Memorandum of Understanding

By signing below, _____ (Dentist/Practice/Clinic Name) agrees to participate in the Lifelong Dental Program. I/We have read the Lifelong Dental Program Manual and understand that I/we will contract with Public Health – Seattle & King County. I/We understand that (a) I/we may only bill for patients referred by Lifelong, (b) I/we agree to inform Lifelong Dental Program staff about subsequent appointments and (c) I/we will send claim forms to Lifelong within ten business days after the delivery of services. I/we understand that reimbursement for dental services provided is set forth in the attached LDP Dental Fee Schedule.

Practice Name (legal business name): _____

Practice Address: _____

Telephone: _____ Fax: _____

Primary contact (if different): _____ Title: _____

Email address for primary contact person: _____

UEI: _____

Specialties (if applicable): _____

Checks should be made out to: _____

TIN: _____

Please provide an estimate on the number of unduplicated Lifelong clients you believe you will be able to see _____
each
month: _____ Title: _____

Name _____ Date: _____
(Print):

Signature:

Please attach a list of the dentist(s) name(s), copies of current dental licenses, a list of currently accepted dental insurance carriers, and a W9 form (only required for new dental providers). Fax or send the requested information to:

Lifelong Dental Program
4634 E Marginal Way S,
Suite C200 Seattle, WA
98134

Fax: (206) 960-4847



**KING COUNTY
SUBSTITUTE W-9**

**Request for Taxpayer Identification number and
Certification**

**Give form to King County.
Do not send to IRS.**

Name (as shown on Invoice)

Business Type

- Association C-Corporation S-Corporation Disregarded Entity
- Division Government Individual
- Limited Liability Company: Enter tax classification (C=C-Corporation, S=S-Corporation, P=Partnership)

Non Profit Partnership Sole Proprietor Trust/Estate

Business Registration Information

Enter where you are registered to do business and the corresponding State Registration Number

State:

Registration Number:

Purchasing Location Information

Physical Address

City , State, and Zip

Remittance Information

Remit Address (if different than above)

City , State, and Zip

Tax Reporting Name and Tax Identification Number or Social Security Number

Enter your Tax reporting Name and address. The Tax Identification number provided must match the name given on the "Tax Reporting Name" line. For individuals, this is your social security number (SSN). Tax Reporting Name

Tax Reporting Address

Tax Reporting City, State, and Zip

Tax Identification Number, Employer Identification Number or Social Security Number (enter numbers only):

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct tax reporting name and identification number.
2. I am a U.S. citizen, U.S. person or U.S. Business Entity.
3. I am not subject to backup withholding due to failure to report interest and dividend income.
4. I am exempt from FATCA reporting. **Certification instructions.** If you are not a U.S. citizen, U.S. person or U.S. Business Entity, you must cross out item 2 above. You will need to provide a completed King County W9 form as well as a copy of your W-8.

Sign Here ▶

Print Name of Signer

Date Signed

Client Maximum Appeal

On behalf of Public Health Seattle & King County, Lifelong Dental Program will review appeals to the client annual maximum expenses allowed based on medical necessity only. If Lifelong Dental Program approves the request, payment is still subject to all general conditions of the program, including contractual limits, client eligibility, insurance, and program restrictions. Lifelong Dental Program will notify the provider and client of the decision.

Limit one exception per provider per year. A treatment plan more than \$3,000 must be submitted and approved in writing by Lifelong Dental Program prior to any services being provided.

CLIENT INFORMATION

Client Initials	Click here to enter text.
Client Provide Number	Click here to enter text.
Client Date of Birth	Click here to enter text.

PROVIDER INFORMATION

Provider Name	Click here to enter text.	Date Requested	Click to enter text.
Requestor Contact Email:	Click here to enter text.	Requestor Contact Phone:	Click to enter text.

Explanation why this service is medically necessary. Include the diagnosis, place of service, and description of the proposed treatment. Attach supporting document as necessary.

Primary Diagnosis:	Click to enter.	Secondary Diagnosis:	Click to enter text.
Description of Treatment:	Click here to enter text.		
List all alternative services attempted and found ineffective:	Click here to enter text.		

How is service/treatment related to the client's HIV status?	Click here to enter text.
Explain why this treatment plan cannot be delivered over multiple grant years.	Click here to enter text.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION										POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)										
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX										12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code										
2. Predetermination/Preauthorization Number										13. Date of Birth (MM/DD/CCYY) 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F 15. Policyholder/Subscriber ID (SSN or ID#)										
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION										16. Plan/Group Number 17. Employer Name										
3. Comp Lifelong Dental Program 210 South Lucile Street Seattle, WA 98108										18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other 19. Reserved For Future Use										
OTHER COVERAGE (Mark applicable box and complete items 5-11, if none, leave blank.)										PATIENT INFORMATION										
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)										20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code										
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)										21. Date of Birth (MM/DD/CCYY) 22. Gender <input type="checkbox"/> M <input type="checkbox"/> F 23. Patient ID/Account # (Assigned by Dentist)										
6. Date of Birth (MM/DD/CCYY)					7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)			11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code										
9. Plan/Group Number					10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other															
RECORD OF SERVICES PROVIDED																				
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee										
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
33. Missing Teeth Information (Place an "X" on each missing tooth.)										34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	31a. Other Fee(s)				
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	32. Total Fee				
34a. Diagnosis Code(s)										34b. Diagnosis Code(s)										
(Primary diagnosis in "A")										(Primary diagnosis in "A")										
35. Remarks																				
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION										
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.										38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=Off Hospital) (Use "Place of Service Codes for Professional Claims")										
X Patient/Guardian Signature: _____ Date: _____										39. Enclosures (Y or N) <input type="checkbox"/>										
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)										
X Subscriber Signature: _____ Date: _____										41. Date Appliance Placed (MM/DD/CCYY)										
										42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)										
										43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)										
										44. Date of Prior Placement (MM/DD/CCYY)										
										45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident										
										46. Date of Accident (MM/DD/CCYY)										
										47. Auto Accident State										
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)										TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
48. Name, Address, City, State, Zip Code										53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.										
										X Signed (Treating Dentist) _____ Date: _____										

Appendix E: Insurance Forms Required for Public Health Seattle King County Contract

EXAMPLE ONLY

ACORD **CERTIFICATE OF LIABILITY INSURANCE** DATE (MM/DD/YYYY)
1/3/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Pacific Underwriters Corp. 12611 Des Moines Mem. Dr. PO Box 68787 Seattle, WA 98168	CONTACT NAME: PHONE (A/C, No, Ext): (206) 248-2254 FAX (A/C, No): (206) 248-0130 E-MAIL: Rkunz@PacificUnderwriters.com ADDRESS:														
INSURED Amy J. L. Cook, DDS 321 4th St. SE Auburn, WA 98002	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 80%;">INSURER(S) AFFORDING COVERAGE</th> <th style="width: 20%;">NAIC #</th> </tr> <tr> <td>INSURER A : Aspen American Insurance Company</td> <td></td> </tr> <tr> <td>INSURER B :</td> <td></td> </tr> <tr> <td>INSURER C :</td> <td></td> </tr> <tr> <td>INSURER D :</td> <td></td> </tr> <tr> <td>INSURER E :</td> <td></td> </tr> <tr> <td>INSURER F :</td> <td></td> </tr> </table>	INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A : Aspen American Insurance Company		INSURER B :		INSURER C :		INSURER D :		INSURER E :		INSURER F :	
INSURER(S) AFFORDING COVERAGE	NAIC #														
INSURER A : Aspen American Insurance Company															
INSURER B :															
INSURER C :															
INSURER D :															
INSURER E :															
INSURER F :															

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSD WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	<input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER:					EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	<input type="checkbox"/> AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A			<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	Professional Liability		D006287-12	1/1/2019	01/01/2020	Each Claim \$1,000,000 Aggregate \$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER	CANCELLATION
	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE

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ACORD 25 (2016/03) The ACORD name and logo are registered marks of ACORD

EXAMPLE

ENDORSEMENT NO. 5

This endorsement, effective 12:01 AM, December 1, 2013

Forms a part of policy no.:

Issued to:

By: LEXINGTON INSURANCE COMPANY

ADDITIONAL INSUREDS ENDORSEMENT

The Policy is amended as follows:

Section II. WHO IS AN INSURED of the HEALTHCARE PROFESSIONAL LIABILITY COVERAGE PART is amended by adding the following:

- King County, its Officers, Officials, Employees and Agents in respects to their contract and

but only as respects liability arising out of the conduct of your business.

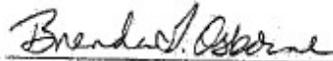
Section II. WHO IS AN INSURED of the HEALTHCARE GENERAL LIABILITY COVERAGE PART is amended by adding the following:

- King County, its Officers, Officials, Employees and Agents in respects to their contract and

Bellicum Pharmaceuticals as per contract ID# BEL-02439

but only as respects liability arising out of the conduct of your business.

All other terms, conditions and exclusions of the policy remain unchanged.



Authorized Representative
or countersignature (where required by law)

79523(502)
HC0310

Appendix F: Specialist Referral



LDP Specialist Referral Form

(WE REQUIRE THE COMPLETION OF ALL FIELDS IN ORDER TO PROCESS IN A TIMELY MANNER)

Client name: _____ Date: _____
 Date of Birth: _____ Phone number: _____

Referring Dental Provider Information

Facility name: _____ Provider name: _____
 Address: _____
 Phone: _____ Fax: _____ Provider Email: _____

Referral Information (Implant supported lower denture needs to be requested using the LDP Specialist Referral Form for Implant Supported Lower Denture)

Endodontics Periodontics Oral Surgery
 Denturist

Describe the procedure and reason for referral: (please specify type of specialist, list each tooth individually and use Tooth Chart):

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16				
			A	B	C	D	E				F	G	H	I	J				
							UR								UL				
							LR								LL				
							T	S	R	Q	P				O	N	M	L	K
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17				

Future treatment plan after specialist treatment is completed:

Please fax referral form to LDP at 206-960-4847
For questions please call 206-957-1716

Revision date: 06/28/19

Appendix G: Specialist Referral for Implant-Supported Lower Denture



LDP Specialist Referral Form for Implant Supported Lower Denture

(WE REQUIRE THE COMPLETION OF ALL FIELDS IN ORDER TO PROCESS IN A TIMELY MANNER)

Client name: _____ Date: _____
 Date of Birth: _____ Phone number: _____

Referring Dental Provider Information

Facility name: _____ Provider name: _____
 Address: _____
 Phone: _____ Fax: _____ Provider Email: _____

Referral Information *Please note that clients should only be referred out for implant supported lower dentures when they are the only option for the client.*

Is the client able to have a complete lower denture without implants?

Yes

No –Please explain below why an implant supported lower denture is the only option for this client

Has the referring dentist determined that the client is a good candidate for two implants to support the lower denture?

Yes

No –We ask that this determination be made prior to the client being referred out for the two implants to support the lower denture

Please indicate on the chart below where the two lower implants would need to be placed

										I.R.																				
										T	S	R	Q	P		O	N	M	L	K										
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17															

Future treatment plan after specialist treatment is completed:

Please fax referral form to LDP at
 206-960-4847. For questions please call
 206-957-1710

Revision date: 10/26/22