ADN DENTAL NETWORK
PROVIDER PARTICIPATION AGREEMENT

This Agreement between ADN Dental Network, Inc. (ADN) and myself and/or my company as a provider of dental services is being made in consideration of the following:

I represent that I am duly licensed to practice dentistry in the State of Michigan and, am agreeable to offer dental services to clients referred to my practice by ADN. In consideration of my participation in the ADN provider network, I agree to provide dental services to ADN members and also maintain records of the services provided.

I further agree to accept, as payment for these services, the lesser of my current Usual, Customary and Reasonable (UCR) fee normally charged to my other non-ADN patients or the ADN fee schedule. Any balance bill to ADN patients over this amount will be only for any plan deductibles, copayments, coinsurance's or non-covered services which are noted on the Explanation of Benefits submitted with payment from the plan. Any balance bill will also be based on the lesser of my UCR charge or the ADN fee schedule. I further agree to verify, upon request from ADN, that the fees charged are my UCR fees charged to all my patients.

This will also verify that I am an independent contractor and not an agent of ADN and I agree to hold ADN harmless from any liability due to any negligence on my part or on the part of anyone in my employ.

This Agreement shall remain in full force and effect unless terminated by either party. Either party may terminate this Agreement with at least sixty (60) days written notice, such termination to be effective on the first day of the month following the sixty days in the notice.

Print Provider Name	Provider Signature
Practice Name	Date
Street	License Number
City / Zip Code	Tax ID (TIN) or Social Security Number (enter number used for claim submission)
Phone Number	Specialty