

**REQUEST FOR DENTAL GROUP ACCOUNT**  
*Complete a separate form for each Practice Location.*

Name of Account \_\_\_\_\_

Practice Address \_\_\_\_\_  
*(P.O. Box Numbers will NOT be accepted)*

Mailing Address \_\_\_\_\_  
*(If Applicable)*

Phone # \_\_\_\_\_

FAX # \_\_\_\_\_

**THIS SECTION MUST BE COMPLETED**

IRS # \_\_\_\_\_

***Copy of notification or coupon from the IRS must be attached.***

Type of Corporation (check one):     Professional     Business     Partnership

**NAME(S) OF DENTAL GROUP ACCOUNT MEMBERS**

DENTIST NAME <i>(typed/printed)</i>	UCCI PROVIDER NO. <i>(if known)</i>	SOCIAL SECURITY NUMBER	SPECIALTY	INDIVIDUAL DENTIST SIGNATURE (*)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please indicate the Dental Network(s) in which you wish to enroll\*:

- UCCI-Parnet     Concordia Preferred     PaBS Penndental     National Fee for Service/TDP

*(\*) By my signature, I agree to abide by the Dental Group Account Agreement listed on the **reverse** side of this form.*

**United Concordia Companies, Inc.**  
**Dental Group Account Agreement**

1. We hereby agree that \_\_\_\_\_ (the "Account") will bill only for those services performed by the individual members of the Account.  
*(Account Name)*
2. We certify that the IRS Number given for the Account is the one assigned to the group. If this is not the case, we will identify the entity whose IRS Number is being used.
3. We certify that each member of the Account agrees to assign his/her fee to the Account.
4. We agree that every claim submitted for United Concordia Companies, Inc. subscribers/beneficiaries will identify the individual provider who performed the service.
5. We agree that the Account and each individual member will be jointly and severally liable for any overpayment that the Account may receive.
6. We agree to notify United Concordia Companies, Inc. in writing of any subsequent changes in the membership of the Account prior to the effective date of each change.
7. We agree to timely completion and return of the United Concordia Companies, Inc. *Dental Group Account Information Update* form. This form will be mailed to the Account each year for verification of current Account membership, location of practice, specialties of member providers, and other pertinent information. We understand that failure to respond may result in the termination of the Dental Group Account.
8. We have carefully reviewed the *Request for Dental Group Account* and *Dental Group Account Agreement*, and each member has verified the accuracy and completeness of all information provided.

On behalf of the group, I verify that all members have reviewed this document and have authorized me to sign this Agreement on behalf of the Group.

\_\_\_\_\_  
Signature of Authorized Representative of Group  
(Must be a Professional Member of this Account.)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Area Code/Phone Number