Delta Dental of Idaho
Advance Claim Payment Program

This program is intended to provide financial support to Delta Dental in-network dentists with practices in Idaho state that have been significantly affected by office closures as a result of COVID-19. Delta Dental of Idaho is committed to partnering with you through these unprecedented and unpredictable times.

To supplement other forms of financial relief offered by Federal or State agencies and financial institutions, DDID is offering Idaho-based dental practices with Member Dentists the opportunity to apply for an advance of future DDID claims payments of up to $10,000 per Tax Identification Number (TIN).

Eligibility:

- Must be an Idaho-based independent practice (TIN) with active in-network dentist(s) with Delta Dental of Idaho.
- Must be in good standing with Delta Dental of Idaho and the Idaho Board of Dentistry.
- Must agree to participate in Delta Dental of Idaho's electronic payment and billing program by October 5, 2020
    - ACH
    - Electronic claim submission
    - Use of our secure dentist web portal or ProFax for Benefits and Eligibility questions
    - Delta Dental of Idaho HOW program (PreViser®)
- Must continue to provide emergency services at a minimum.

Program Specifics:

• Allows an advance of future DDID claims payments equal to the lessor of $10,000 or 100% of average monthly claims paid from January 1, 2019 through December 31, 2019 for an Idaho-based TIN.

– Application period extends from April 6, 2020 to May 22, 2020.

• 0% interest rate on advance.

• Repayment will be made through withholding of 15% of claim payments commencing with the October 5, 2020 claims run until repaid in full. Any remaining balance as of April 1, 2021 would be due and payable as a final balloon payment.

Delta Dental of Idaho Advance Claim Payment Program Application

— All fields are required—

Each dentist applying to this program must fill out a separate form.

Practice/Business Owner Name _____

Practice/Business Owner TIN # _____

Office/Business Name _____

Office/Business Address _____

City _____ State _____ Zip Code _____

Office Phone _____

Name of dentist applying: _____

The following are needed so we may easily reach you and verify your request:

Personal Cell _____

Personal Email

_____

Email completed form to: Accounting@deltadentalid.com

Payment will be made by ACH to the account on file. If no ACH account is on file, payment will be made by check and mailed to the address above.