

Dental Savings Fee Schedule (General Dentist)

Dentists may add additional lab fees to discounted services with.

DIAGNOSTIC & PREVENTATIVE Fee

D0120 Periodic Oral Evaluation	\$20
D0150 Comprehensive Oral Evaluation	\$30
D0210 Xrays – Complete Series	\$60
D0274 Bitewings – Four Films	\$35
D0330 Panoramic Film	\$65
D1110 Prophylaxis – Adult Cleaning	\$55
D1120 Prophylaxis – Child Cleaning	\$45
D1203 Fluoride	\$15
D1351 Sealant – Per Tooth – No Age Limit	\$30

1 FREE DENTAL CLEANING (PROPHY) PER YEAR PER CARDHOLDER

- Exams & Xrays Not Included -

RESTORATIVE Fee

D2140 Amalgam – One Surface	\$55
D2150 Amalgam – Two Surfaces	\$75
D2160 Amalgam – Three Surfaces	\$85
D2161 Amalgam – Four Surfaces	\$105
D2330 Resin Based Composite – One Surface - Anterior	\$60
D2331 Resin Based Composite – Two Surfaces - Anterior	\$80
D2332 Resin Based Composite – Three Surfaces - Anterior	\$115
D2391 Resin Based Composite – One Surface - Posterior	\$80
D2392 Resin Based Composite – Two Surfaces - Posterior	\$105
D2393 Resin Based Composite – Three Surfaces - Posterior	\$140
D2394 Resin Based Composite – Four Surfaces - Posterior	\$170
D2750 * Crown – Porcelain Fused to High Noble Metal*	\$875
D2950 Core Buildup – Including any Pins	\$135
D2954 Prefabricated Post & Core	\$155

ENDODONTICS Fee

D3310 Root Canal – Anterior	\$500
D3320 Root Canal – Bicuspid	\$600
D3330 Root Canal – Molar	\$700

PERIODONTICS Fee

D4210 Gingivectomy Per Quad	\$400
D4211 Gingivectomy Per Tooth	\$200
D4341 Perio Scaling/Per Quadrant	\$70
D4381 Localized Delivery of Antimicrobial Agents Via a Controlled Release Vehicle into Diseased Crevicular Tissue - Per Tooth, By Report	\$50 Per Site

PROSTHODONTICS Fee

D5110 *Complete Denture – Maxillary*	\$800
D5120 *Complete Denture – Mandibular*	\$800
D5213 *Maxillary Partial - Denture Bases* (Including any Conventional Clasps, Rests or Teeth)	\$875
D5214 *Mandibular Partial - Denture Bases* (Including any Conventional Clasps, Rests or Teeth)	\$875
D6010 Implant	20% off UCR fee
D6059 Implant Crown	20% off UCR fee

ORAL SURGERY Fee

D7140 Simple Extraction – Erupted Tooth/Exposed Root	\$85
D7210 Surgical Extraction	\$225
D7220 Removal Impacted Tooth – Soft Tissue	\$175
D7230 Removal Impacted Tooth – Partial Bony	\$200

IN-OFFICE WHITENING SYSTEM 25% Discount

DENTAL SPECIALISTS - 25% DISCOUNT OFF UCR FEES

Oral Surgeon, Periodontist, Endodontist, Orthodontist & Pedodontist

Dentists may add additional lab fees to discounted services with.

*Any Service not listed on Discounted Fee Schedule,
please refer to office private fees.*

*Patients Pay at Time of Service
No Claims, No Waiting, No Limitations*

Vision Savings Fee Schedule

VISION CARE Fee

Routine Eye Exam	\$5 off UCR fee
Exam - Contact Lens	\$10 off UCR fee

1 FREE EYE EXAM PER YEAR PER CARDHOLDER

*Available at Select Participating Provider Locations

LENS OPTIONS Fee

Ultraviolet Coating	25% off UCR fee
Tint – Solid or Gradient	25% off UCR fee
Standard Scratch-Resistance (Scratch A)	25% off UCR fee
Standard Polycarbonate	10% off UCR fee
Standard Progressive	10% off UCR fee
Basic Anti-Reflective Coating	20% off UCR fee
Blended Invisible Bifocal	20% off UCR fee
Intermediate Vision Lenses	20% off UCR fee
Polarized	20% off UCR fee
Other Lens Options/Features	20% off UCR fee

STANDARD LENSES - GLASS OR PLASTIC Fee

Single	10% off UCR fee
Bifocal	10% off UCR fee
Trifocal	10% off UCR fee
Frames	25% off UCR fee

CONTACT LENSES Non-Disposable: 15% Discount

NON-PRESCRIPTION SUNGLASSES 20% off UCR fee

LASER CORRECTION PRK, LASIK, & Custom LASIK: 15% off UCR fee

CHP  (888) 926-5041

www.communityhealthplans.com

Fee Schedule Last Updated: 5/30/17



VISION PROFESSIONALS INFORMATION FORM

Fax to: (800) 556-5690 Email to: providers@communityhealthplans.com

PRACTICE INFORMATION *(*Information included in Directory Webpage Practice Profile)*

*Office Name: _____ Tax ID #: _____

*Address: _____
Street City State Zip

*Phone: _____ Fax: _____

Contact Name: _____ Title: _____

Tax ID #: _____

Professional Liability Insurance Carrier: _____ Expiration Date: _____

Hours of Operation

- Monday _____
- Tuesday _____
- Wednesday _____
- Thursday _____
- Friday _____
- Saturday _____
- Sunday _____

Website Links

Practice Website: _____
 Facebook: _____
 Twitter: _____

Online Appointment Requests Recipient Information *(required)*

Email: _____
 Contact Name: _____
 Title: _____

VISION PROFESSIONALS INFORMATION *(For additional vision professionals you would like listed on our Online Marketing Directory, Social Media Pages and included in our Vision Marketing Program, please complete Additional Vision Professionals Form.)*

First Name: _____ Last Name: _____ MD/DO

Eye Doctor Optician Optometrist Ophthalmologist Low Vision Specialist

Drivers License: _____ Expiration Date: _____

State License #: _____ Expiration Date: _____

DEA #: _____ Expiration Date: _____

BILLING INFORMATION - \$300 Annual Marketing/Advertising Fee per Vision Office Location *(required)*

of Dental Professionals: _____ Amount Billed Annually: _____ Visa MasterCard AMEX Discover

Name on Card: _____
First Last

Card Number: _____ Exp. Date: _____ CVV Code: _____

Billing Address: _____
Street City State Zip

I confirm that the information submitted to Community Health Plans is accurate and true and authorize CHP to charge the agreed recurring annual marketing/advertising fee listed above to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Signed: _____ Dated: _____



ADDITIONAL VISION PROFESSIONALS FORM

Fax to: (800) 556-5690 Email to: providers@communityhealthplans.com

First Name: _____ Last Name: _____ MD/DO

Eye Doctor Optician Optometrist Ophthalmologist Low Vision Specialist

Drivers License: _____ Expiration Date: _____

State License #: _____ Expiration Date: _____

DEA #: _____ Expiration Date: _____

First Name: _____ Last Name: _____ MD/DO

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First Name: _____ Last Name: _____ MD/DO

Eye Doctor Optician Optometrist Ophthalmologist Low Vision Specialist

Drivers License: _____ Expiration Date: _____

State License #: _____ Expiration Date: _____

DEA #: _____ Expiration Date: _____

COPIES TO ATTACH FOR VISION PROFESSIONAL *(*if applicable)*

DEA Certificate* CRS Certificate* License Medical Malpractice Insurance Current State Registrations W9 Form

Upon set up of your account, all copies of the requested documents must be added to document vault in the provider login portal within 72 hours of application processing. Community Health Plans will not be held liable under any circumstances for failure to do so and/or incomplete or inaccurate information.

FREE PATIENT EYE EXAM OPT-IN *(optional)*

I agree to offer 1 FREE Eye Exam per year per cardholder.

Signed: _____ Dated: _____

CHPO Vision Marketing Program

Total Marketing Package Valued at \$1000 for Only \$300 per Location!



E-MAIL MARKETING

We send out scheduled email campaigns with your practice information, website and social media links to our network.

Valued at \$300



SOCIAL MEDIA

We create custom social media posts with your practice information on Community Health Plans Social Media pages. Share It, Like It, Tweet It.

Valued at \$500



NEWSLETTER

Your practice will be featured in our monthly and holiday newsletters and distributed to our CHP members in your local area.

Valued at \$200

Marketing Program Benefits

- ✓ Increase Visibility to New Patients
- ✓ A Listing on Our Online Directory
- ✓ Customize Listing with Photos & Office Hours
- ✓ We Link to Your Website & Social Media
- ✓ We Tag Your Practice on Our Social Media Posts
- ✓ Patient Online Appointment Requests



Have Exclusivity in Your Zip Code **Secure Your Spot!**

We limit the number of vision professional listings on our Marketing Directory to a total of 20 providers per zip code. This means greater visibility to our members for your practice. The benefit of a smaller vision network will increase in-office patient retention making patients more likely to stay active within your practice.

We Give Back to the Local Community

10% of Your Marketing Fee Goes to Benefit Local Non-Profit Healthcare Causes

Increase New Patients to Your Practice with Our Marketing Program

FAX YOUR PRACTICE FORMS TODAY! (800) 556-5690



About Us

Community Health Plans (CHP) is the fastest growing discounted dental and vision savings program with a national network of participating providers. We are the only free dental and vision savings card. We specialize in creating a provider marketing program that will immediately increase the number of new patients to your practice.

Who We Are

CHP was created by healthcare professionals who understand the healthcare industry and recognize some of the challenges associated for healthcare providers and patients alike. These professionals were committed to finding an in-office solution to combat limitations of traditional healthcare. For you, the provider, it's a means to create a new marketing lead source that will increase the number of new patients for your practice immediately.

A Unique Approach

At Community Health Plans, we take a very different approach to growing our network in comparison to other savings plan programs. We specialize in asking our members to refer dental and vision care providers that they know, trust and have a great reputation in their community. We pride ourselves in being the only provider community that is built organically leaving members with a sense of trust and our dentists and eye care specialists with a sense of exclusivity.

Enclosed, you will find our dental professional forms, our schedule of discounted dental and vision services, and our marketing program highlights for your review.

Thank you for your time and consideration, we look forward to working with you.

Community Health Plans

Monday through Friday, 9a.m. to 5p.m

Customer Service Line: (888) 926-5041

www.communityhealthplans.com

Email Application to: providers@communityhealthplans.com

or

Fax Application to: (800) 556-5690