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@coummunityhealthplans.com
or
Fax Application to: (800) 556-5690

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 -

**Available at Select Participating Provider Locations*

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 addtional vision professionals you would like listed on our Online Marketing Directory, Social Media Pages and included in our Vision Marketing Program, please complete Addtional 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: _____

OPTIONAL MARKETING ADD ON'S *(Please see Marketing Sell Sheet for Details*

❑ Marketing Option 1 - $180 annually ❑ Marketing Option 2 - $300 annually ❑Marketing Option 3 - $600 annually

Billing Information Card Type: ❑ 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 reoccurring annual or monthly marketing/advertising charge to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. I also understand that if offered a monthly recurring payment option, that I must remain in the program for at least 90 days or three billing cycles and that I need to submit my cancellation request in writing. If I choose a yearly reoccurring payment, I understand that no refunds are extended in the first year and to cancel for subsequent years, I must send in notification in writing 30 days before the next annual billing/renewal date.

Signed: _____ Dated: _____

CHP Community Outreach Program

Marketing Solutions That Works for Your Practice

Email Blast to Members Announcing Participation

Custom Social Media Posts to Increase Visibility

Text Alerts to Members Announcing Participation

Featured Practice Listing in Our Monthly Newsletter

Please Select the Program that Best Fits Your Practice

Join the only community outreach savings program that offers 3 robust marketing and advertising solutions to increase new patients and brand awareness for your practice.

CHP Basic Participation
FREE

- Customizable Practice listing on our online search directory
- Fast & Easy Secure Login to Check Eligibility online

CHP Marketing Option 1
$180 annually

- Customizable Practice Listing on Our Online Search Directory
- Links to Website & Social Media
- Automated Emails with Your Practice Information to All CHP Members in Your Area
- Fast & Easy Secure Login to Check Eligibility Online

CHP Marketing Option 2
$300 annually

- Sign Up Unlimited Providers in Your Office to Increase Visibility
- Customizable Practice Listing on Our Online Search Directory
- Your Own Practice Landing Page on communityhealthplans.com
- Featured Placement in Our Monthly Email Newsletter
- Automated Emails with Your Practice Information to All CHP Members in Your Area
- 5 Social Media Posts Promoting Your Practice & Participating Providers
- Fast & Easy Secure Login to Check Eligibility Online

CHP Marketing Option 3
$600 annually

- Text Alerts to New Members in Your Area Announcing Your Participation
- Featured Placement on all Employee Health Plan Marketing
- Featured Placement in Our Monthly Email Newsletter
- 4 Quarterly Emails to All Members in Your State Announcing Your Participation
- 12 Social Media Posts Promoting Your Practice through the Year
- Customizable Practice Listing On Our Online Search Directory
- Your Own Practice Landing Page on communityhealthplans.com
- Fast & Easy Secure Login to Check Eligibility Online
- Sign Up Unlimited Providers in Your Office to Increase Visibility

Have Exclusivity in Your Zip Code Secure Your Spot!

We limit the number of dental professional listings on our Marketing Directory to a total of 10 providers per zip code. This means greater visibility to our members for your practice. The benefit of a smaller dental network will increase in-office patient retention making patients more likely to stay active within your practice.

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

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

❑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

❑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

❑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 heald 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: ________________