151 Farmington Avenue
Hartford, CT 06156

Dear Dental Provider,

Thank you for your interest in becoming a part of the Aetna network of participating dentists.

Please electronically complete the application in its entirety.

- Please note: Submission of an application is only a request for participation. It does not indicate Aetna's acceptance into our network or guarantee your participation in the Aetna network. Aetna will evaluate your application according to our business and credentialing processes and standards.

- Important: When completing the application, the system will timeout after 60 minutes and your work will not be saved.

- Your inquiry will be assigned to one of our dedicated Provider Relations team members that will work directly with your office to answer any questions and guide you through the contracting requirements.

- You should anticipate a response within the next 14 days; however, if you require immediate assistance, please contact our Customer Service team at 1-800-451-7715.

- **Please begin by clicking the yellow "Start" button on the left side of the page.**

Thank you,

Aetna Dental

aetna®

Dentist Application

Complete this form in its entirety.

☐ New Office
☐ Adding an Additional Location

☐ Adding Associate Only
☐ Ownership Change

Individual Dentist Information

Must be completed by each dentist requesting participation.

Last Name	First Name	Middle Initial	Degree

Date of Birth *(MM/DD/YYYY)*	Gender ☐ Male ☐ Female	Telephone Number	National Provider Identification Number (NPI)

Are you eligible to lawfully work in the U.S.? ☐ Yes ☐ No	Language(s) spoken?

Specialty
☐ General Dentist ☐ Oral Surgeon ☐ Pedodontist ☐ Periodontist ☐ Endodontist ☐ Orthodontist ☐ Prosthodontist ☐ Other: _____

B. License & Certificate Information – Attach current/valid copies.

Type License	State	License Number	Issue Date	Expiration Date
Dental License (1)				
Dental License (2)				
DEA Certificate*				
CDS Certificate, if applicable				
Specialty Certificate or License, if applicable				
General Anesthesia / IV Sedation / Conscious Sedation Certificate, if applicable				

***IF NO DEA:** **Please explain or comment:**

Have you already applied? ☐ **Yes** ☐ **No**

Are you eligible to apply? ☐ **Yes** ☐ **No** ☐ **N/A**

Have you ever been denied? ☐ **Yes** ☐ **No** ☐ **N/A**

C. Work History - Most recent 5 years. ***Attach Curriculum Vitae, if available. Please explain any gaps of 6 months or more since the date of graduation from dental school.***

Name of Practice	Position	Specific Date Range (Month/Day/Year)	Address

D. Education & Training

Dental School Attended		Year Graduated
City	State	Country

Specialty School Attended		Year Graduated
City	State	Country

Office Information

A. Practice Information

Individual/Corporate Name (must match the first line on W-9)	**Group National Identification Number (NPI), if applicable**
How would you like your name to appear in the directory?	Owner Name

Are there in-house Specialists?
☐ Yes ☐ No **If Yes, which specialties?**
☐ Oral Surgeon ☐ Pedodontist ☐ Periodontist ☐ Endodontist
☐ Orthodontist ☐ Prosthodontist ☐ Other: _____

B. Primary Servicing Location

Street Address			Suite
City	State	ZIP Code	County

TIN	Telephone Number	Fax Number	Public Email Address (email will link to office from Docfind)

Web Address: web address will provide link to office from DocFind

C. Administrative Billing Address – Note: *If different from service location, patient rosters and checks will be sent to administrative address only.*

Street Address	Suite	City	State	ZIP Code	County

Telephone Number	Fax Number	Administrative Email Address (For Aetna use)

All mail should be sent to: ☐ This location ☐ Individual office location(s)

D. Office Data

Certified Medical Translator? ☐ Yes ☐ No Which languages? _____	Accepting New Patients? ☐ Yes ☐ No	Handicap Accessible? ☐ Yes ☐ No

Office Hours
Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday _____

Please indicate hours of any specialist working within the office: _____

How many calendar days until the first available appointment for:

New Patient Exams: _____ Hygiene Appointments: _____ Recall Appointments: _____
Routine Care Appointments: _____ Emergency Appointments: _____

E. Additional Locations

Group Name		TIN	Handicap Accessible? ☐ Yes ☐ No
Street Address	Suite	Languages Spoken by Staff	
City	State / ZIP Code	Telephone Number	Fax Number
County		Email Address	

Group Name			TIN	Handicap Accessible? ☐ Yes ☐ No
Street Address		Suite	Languages Spoken by Staff	
City	State	ZIP Code	Telephone Number	Fax Number
County			Email Address	

Group Name			TIN	Handicap Accessible? ☐ Yes ☐ No
Street Address		Suite	Languages Spoken by Staff	
City	State	ZIP Code	Telephone Number	Fax Number
County			Email Address	

Confidential Information

Must be completed by each dentist requesting participation.

Provider Name	Office Tax ID	Date Signed

Instructions

The information requested on this form will be used in the Aetna Dental® credentialing process. The questions are intentionally worded to solicit as much information as possible for review and consideration. It is important that the information you provide be as complete and accurate as possible because any misstatement or omission of relevant information will constitute grounds for rejection of your application or summary dismissal as a participating provider. Thus, it is better to err on the side of inclusion with appropriate explanation, rather than exclusion. In addition, you will be held responsible for all information provided in the application, regardless of whether it was prepared by you or by an employee or representative.

If you answer YES to any questions below, please attach a detailed explanation.

Please answer the following questions.	**Yes**	**No**	**N/A**
1. In the past 5 years, have you had any adverse action taken or is an adverse action pending with respect to any of the following items?			
a. State License/Certification/Registration.	☐	☐	
b. DEA registration or other applicable narcotic registration.	☐	☐	☐
c. Medicare, Medicaid or other government health program participation.	☐	☐	☐
2. Do you currently have a physical or mental condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety? (Physical or mental condition includes, but is not limited to, current alcohol or drug dependency, current participation in aftercare programs for alcohol or drug dependency, medical limitations of activity or workload, and prescribed medication that may affect your clinical judgment or motor skills.)	☐	☐	
3. In the past 5 years, have you been involved in any malpractice action(s), including litigation, arbitration or mediation, or a pre-suit settlement agreement, regardless of the method or amount of the outcome that resulted?	☐	☐	
4. In the past 5 years, has your professional liability insurance or coverage been denied, suspended, canceled, lapsed, not renewed, special rated or experienced gaps?	☐	☐	
5. In the past 5 years, have you been convicted of, or under indictment for, a crime?	☐	☐	

6. In the past 5 years, have you been the subject of an administrative, civil or criminal complaint or investigation regarding sexual misconduct or child abuse? ☐ ☐

(If you previously told us of the event and there has been activity or change, mark "Yes" and explain the activity or change.)

7. Are you Board certified for your specialty? If "Yes", date of certification. _____ (N/A for General Dentist) ☐ ☐ ☐
Please attach a copy of the certification.

8. Do you have hospital admitting privileges? If "Yes", what hospital? _____ ☐ ☐

Aetna will not disclose information that is protected by law from disclosure.

Release and Authorization

In order to more completely evaluate my application for inclusion in the Aetna Dental® panel of dentists and my continuing participation status with Aetna Dental in the event my application is accepted, I authorize Aetna Inc., and its subsidiaries, affiliates, successors, employees and agents (hereinafter "Aetna Dental"), to consult with hospitals, members of hospital medical staffs, professional liability carriers, managed care organizations and other persons or entities to obtain information concerning my professional credentials and qualifications, including without limitation my professional competence and conduct. Specifically included in this authorization to obtain information, but not way of limitation is information about my quality of care and utilization statistics from the chiefs of the clinical departments of a hospital in which I have staff privileges, professional state boards, applicable state and federal agencies, and primary care and specialist physician colleagues participating with Aetna Dental.

I consent to the release to Aetna Dental of any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged. I authorize Aetna Dental to release this information, as well as quality assurance data relating to me: (1) to health/dental benefit plans/programs owned, managed or administered by Aetna Dental, (2) to medical/dental groups, independent practice associations and similar entities contracting with said health/dental plans/programs has delegated credentialing functions to such entities, and (3) as authorized under state or federal law or regulation. I release Aetna Dental and any and all persons or entities providing information about me to Aetna Dental, from any and all liability connected with or arising from the release of such information, provided that such party(ies) was (were) acting in good faith without malice. I further release Aetna Dental from any and all liability for its acts performed in good faith and without malice in evaluating my application and any decisions related to my application or credentialing status.

I understand that I have the burden of proving adequate information to Aetna Dental to demonstrate my qualifications. I understand and agree that any misstatement or material omission in this application will constitute grounds for rejection of my application or summary dismissal as a participating provider in any and all managed care products or plans maintained or managed by Aetna Dental. If any material changes occur in the information I have provided in this application making such information no longer correct and complete or affecting my professional status, I understand and agree that it is my obligation to notify Aetna Dental or the appropriate subsidiary or affiliate with ten (10) days of said occurrence. Failure to comply with this obligation may constitute grounds of rejection of my application or summary dismissal as a participating provider in any and all managed care products or plans maintained or managed by Aetna Dental.

I attest that the information contained in this application is correct and complete.

Name (First, Middle Initial, Last) - Please Print
Signature (No Signature Stamp) **X**
Date

Application Attachments

Professional Liability Insurance Face Sheet (Mandatory)

State Dental License

DEA

CDS

Specialty Certificate or License

General Anesthesia Certificate/License

Curriculum Vitae (CV)

Confidential Information Questions Detailed Explanations

OTHER Attachments – Use to attach additional documents not listed above.

Comments: