New/Additional Location Form

Cigna Dental

CLEAR FORM

Applying for:

☐ **DHMO** (includes Medical Oral Surgeons) ☐ **DPPO**

ACTION REQUIRED

1. Go to https://ada.org/credentialing" ada.org/credentialing (ADA membership not required)
2. If you do not have a profile, create a new profile for free
3. If you do have a profile, update the profile to allow Cigna to access it and re-attest to the information
4. Complete this page and submit it with your signed contract

CAQH ID: _____

Specialty

☐ General Dentistry ☐ Endodontics ☐ Oral Surgery ☐ Orthodontics ☐ Pediatric Dentistry ☐ Periodontics ☐ Prosthodontics

☐ Dental Therapist ☐ Registered Dental Hygienist ☐ Advanced Dental Therapist ☐ Denturist ☐ Dental Health Aide Therapist

Dental Practitioner Name (Last)*	(First)*	(Middle Name)*	(Suffix)	Alternate preferred name (the name you would like listed on the online directory)

Title	Social Security Number	Date Of Birth	Gender: ☐ Male ☐ Female

**Last name, First name, and middle name exactly as it appears on your Dental and/or Medical License*

Dental Practitioner License Number	Dental Practitioner NPI	Name of Office	Office NPI

☐ This Location Only ☐ Multiple Locations (CAQH or Attached List)

Office Address (Street) (Suite #) (City) (State) (Zip Code)	Telephone	Fax

Foreign languages spoken by the Dental Practitioner	Foreign languages spoken in the office	Languages spoken by a Qualified Medical Interpreter

Billing/Mailing Address if different (Street) (Suite #) (City) (State) (Zip Code)

Dental Practitioner Email Address	Office Email Address

Authorizing Dentist(s) (if applicable)	Supervising Dentist(s) (if applicable)
Corporate Contact Name	Corporate Contact Email Address

☐ Yes By checking yes you are attesting that all office email addresses are intended for patient communication, are regularly monitored, and are maintained in a manner consistent with state and federal health privacy laws.

☐ No By checking no you are attesting that the provided email address will not be listed on the online directory.

Office Manager Name	Office Manager Email Address	Office Manager Telephone

Future Start Date? ☐ Yes ☐ No Future Start Date: _____

After Hours/Emergency Coverage

☐ Answering Service ☐ Coverage by Another Office ☐ Answering Machine ☐ Emergency Telephone: _____

☐ Other: _____

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Office Hours

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

Please answer EACH question below:

1. Does your practice include a mobile unit? ☐ Yes ☐ No
2. Does your office provide the following:
   General Anesthesia / IV Sedation (Do not consider Non-IV Sedation services in your response. Response required from OS & PE.) ☐ Yes ☐ No
   Nitrous Oxide ☐ Yes ☐ No
3. Does office meet all federal and state requirements, including ADA, OSHA, CDC Infection Control recommendations? ☐ Yes ☐ No
4. Accommodations adequate for handicapped/disabled patients or office is otherwise considered compliant under the Americans with Disabilities Act? ☐ Yes ☐ No
5. Do you accept and treat patients with disabilities (including, but not limited to, HIV positive/AIDS and Hepatitis B carrier) in accordance with the requirements of the Americans with Disabilities Act and professionally recognized standards? ☐ Yes ☐ No
6. Is Teledentistry offered at the practice? ☐ No ☐ Video ☐ Audio-Only

☐ Owner ☐ Associate If Associate, name of Owner? _____

Tax ID*	Tax ID Type	Name Associated with Tax ID Number

For New DHMO Offices Only:

Number of Staff

General Dentist: Full Time _____ Part Time _____ Assistants/Other Staff: Full Time _____ Part Time _____

Hygienists: Full Time _____ Part Time _____ How many dental chairs are in office? _____

Total number of Cigna Dental Health (CDH) DHMO patients that the office will accept? _____

Wait Times

What is your wait time for the following appointment types?

Initial: _____ Weeks Restorative visit: _____ Weeks Recall: _____ Weeks Reschedule of Appts: _____ Weeks Routine: _____ Weeks

Urgent: _____ Hours Adult hygiene visit: _____ Weeks In office waiting room wait time: _____ Minutes Child hygiene visit: _____ Weeks

Patient Care (Please indicate the services routinely performed in your office)

Endodontics

Anterior root canal treatment: ☐ Yes ☐ No Bicuspid root canal treatment: ☐ Yes ☐ No First molar root canal treatment: ☐ Yes ☐ No

Restorative

Amalgam restorations: ☐ Yes ☐ No Composite restorations: ☐ Yes ☐ No

Pediatric Dentistry

Routine care for children (Less than 13 years of age): ☐ Yes ☐ No

Periodontics

Scaling/root planning: ☐ Yes ☐ No

Oral Surgery

Erupted tooth surgical removal: ☐ Yes ☐ No

***NOTE:** Payments due hereunder to Dental Practitioner by Cigna shall be made payable to Dental Practitioner unless Dental Practitioner identifies the name and federal tax identification number of another payee above. By naming said Payee, Dental Practitioner authorizes all amounts due hereunder and releases Cigna from any and all obligation to make payments to Dental Practitioner.

I authorize Cigna Dental to activate my participation into the network plan(s) at the additional location(s) noted and agree to abide by the terms of the contract(s) signed:

Dental Practitioner Signature**	Please Print Name	Date
X		

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