



TEXAS PROVIDER CREDENTIALING APPLICATION

IT IS REQUIRED THAT YOU INCLUDE THE FOLLOWING DOCUMENTATION WITH YOUR CONTRACTING DOCUMENTS TO BECOME A LIBERTY DENTAL PLAN PROVIDER.

Individual Provider Credentialing Applications are necessary for the Practice Owner and for EACH Associate Dentist rendering services.

The State of **TEXAS** has mandated the use of their State Credentialing Application. It is only necessary to complete the following pages for LIBERTY'S credentialing process:

- **Pages 1 – 4** (Filled in completely – Page 3 requires 5 years of Work History or back to graduation date – CV's not accepted unless current)
- **Page 5 – 6** (Check yes or no)
- **Pages 7 – 8** (Sign and date)
- **Attachments A and B**
- **Attachment G** (As applicable to your Attestation – must sign and date)

Include current copies of the following:

- Dental License
- DEA License
- Malpractice Insurance (Declaration Page)
- Specialty Certificate (if applicable)



Texas Standardized Credentialing Application

(Please type or print)

Section I-Individual Information

TYPE OF PROFESSIONAL DENTAL			
LAST NAME		FIRST	MIDDLE (JR., SR., ETC.)
MAIDEN NAME	YEARS ASSOCIATED (YYYY-YYYY)	OTHER NAME	YEARS ASSOCIATED (YYYY-YYYY)
HOME MAILING ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
HOME PHONE NUMBER	SOCIAL SECURITY NUMBER		<input type="checkbox"/> Female <input type="checkbox"/> Male
CORRESPONDENCE ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL	
DATE OF BIRTH (MM/DD/YYYY)	PLACE OF BIRTH		CITIZENSHIP
IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS			ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? <input type="checkbox"/> Yes <input type="checkbox"/> No
U.S. MILITARY SERVICE/PUBLIC HEALTH <input type="checkbox"/> Yes <input type="checkbox"/> No	DATES OF SERVICE (MM/DD/YYYY) TO (MM/DD/YYYY)		LAST LOCATION
BRANCH OF SERVICE	ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Education

PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.) Issuing Institution:		
ADDRESS		
CITY		STATE/COUNTRY
DEGREE		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
<input type="checkbox"/> Please check this box and complete and submit Attachment A if you received other professional degrees.		

POST-GRADUATE EDUCATION		SPECIALTY
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Teaching Appointment		
INSTITUTION		
ADDRESS		
CITY		STATE/COUNTRY
<input type="checkbox"/> Program successfully completed		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR		CURRENT PROGRAM DIRECTOR (IF KNOWN)

POST-GRADUATE EDUCATION		SPECIALTY
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Teaching Appointment		
INSTITUTION		
ADDRESS		
CITY		STATE/COUNTRY
		POSTAL CODE

Education - continued		
POST-GRADUATE EDUCATION <input type="checkbox"/> Program successfully completed		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR		CURRENT PROGRAM DIRECTOR (IF KNOWN)
<input type="checkbox"/> Please check this box and complete and submit Attachment B if you received additional postgraduate training.		
OTHER GRADUATE-LEVEL EDUCATION		
Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
Licenses and Certificates - Please include all license(s) and certifications in all States where you are currently or have previously been licensed.		
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> DEA Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
<input type="checkbox"/> DPS Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
OTHER CDS (PLEASE SPECIFY)	NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
UPIN	NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE)	
ARE YOU A PARTICIPATING MEDICARE PROVIDER? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Provider Number:		ARE YOU A PARTICIPATING MEDICAID PROVIDER? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicaid Provider Number:
EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No ECFMG Number:		ECFMG ISSUE DATE (MM/DD/YYYY)
Professional/Specialty Information		
PRIMARY SPECIALTY	BOARD CERTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)
IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY. <input type="checkbox"/> I have taken exam, results pending for _____ Board. <input type="checkbox"/> I have taken Part I and am eligible for Part II of the _____ Exam. <input type="checkbox"/> I am intending to sit for the Boards on _____ (date) <input type="checkbox"/> I am not planning to take Boards.		
DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO: <input type="checkbox"/> Yes <input type="checkbox"/> No PPO: <input type="checkbox"/> Yes <input type="checkbox"/> No POS: <input type="checkbox"/> Yes <input type="checkbox"/> No		
SECONDARY SPECIALTY	BOARD CERTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

Professional/Specialty Information -continued

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.
 I have taken exam, results pending for _____ Board.
 I have taken Part I and am eligible for Part II of the _____ Exam.
 I am intending to sit for the Boards on _____ (date)
 I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: Yes No PPO: Yes No POS: Yes No

ADDITIONAL SPECIALTY	BOARD CERTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Certifying Board:
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.
 I have taken exam, results pending for _____ Board.
 I have taken Part I and am eligible for Part II of the _____ Exam.
 I am intending to sit for the Boards on _____ (date)
 I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: Yes No PPO: Yes No POS: Yes No

PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.)

Work History - Please provide a chronological work history. You may submit a Curriculum Vitae as a supplement. Please explain all gaps in employment that lasted more than six months.

CURRENT PRACTICE/EMPLOYER NAME START DATE/END DATE (MM/YYYY TO MM/YYYY)

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

PREVIOUS PRACTICE/EMPLOYER NAME START DATE/END DATE (MM/YYYY TO MM/YYYY)

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

REASON FOR DISCONTINUANCE

PREVIOUS PRACTICE/EMPLOYER NAME START DATE/END DATE (MM/YYYY TO MM/YYYY)

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

REASON FOR DISCONTINUANCE

PREVIOUS PRACTICE/EMPLOYER NAME START DATE/END DATE (MM/YYYY TO MM/YYYY)

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

REASON FOR DISCONTINUANCE

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/YYYY TO MM/YYYY) IN WORK HISTORY.
Gap Dates: Explanation:
Gap Dates: Explanation:

Hospital Affiliations -Please include all hospitals where you currently have or have previously had privileges.			
DO YOU HAVE HOSPITAL PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE?	
PRIMARY HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES			START DATE (MM/YYYY)
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL	
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
Professional Liability Insurance Coverage			
SELF-INSURED? <input type="checkbox"/> Yes <input type="checkbox"/> No		NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY	
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPES OF COVERAGE <input type="checkbox"/> Individual <input type="checkbox"/> Shared	LENGTH OF TIME WITH CARRIER
NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS			
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPES OF COVERAGE <input type="checkbox"/> Individual <input type="checkbox"/> Shared	LENGTH OF TIME WITH CARRIER
Practice Location Information – Please answer the following questions for each practice location.			PRACTICE LOCATION of
TYPE OF SERVICE PROVIDED <input type="checkbox"/> Solo Primary Care <input type="checkbox"/> Solo Specialty Care <input type="checkbox"/> Group Primary Care <input type="checkbox"/> Group Single Specialty <input type="checkbox"/> Group Multi-Specialty			
GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY		GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9	
PRACTICE LOCATION ADDRESS			
<input type="checkbox"/> Primary			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL	
BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER	
GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER		
ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
OFFICE MANAGER OR STAFF CONTACT		PHONE NUMBER	FAX NUMBER
CREDENTIALING CONTACT			
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL	

Section II-Disclosure Questions - Please *provide* an explanation for any question answered yes-except 16-on page 10.

Licensure

- 1 Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board? Yes No
- 2 Have you ever received a reprimand or been fined by any state licensing board? Yes No

Hospital Privileges and Other Affiliations

- 3 Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? Yes No
- 4 Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? Yes No
- 5 Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? Yes No

Education, Training and Board Certification

- 6 Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? Yes No
- 7 Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? Yes No
- 8 Have any of your board certifications or eligibility ever been revoked? Yes No
- 9 Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? Yes No

DEA or DPS

- 10 Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished? Yes No

Medicare, Medicaid or other Governmental Program Participation

- 11 Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? Yes No

Other Sanctions or Investigations

- 12 Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program? Yes No

Section II - Disclosure Questions - continued

Other Sanctions or Investigations

- 13 To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? Yes No
- 14 Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? Yes No
- 15 Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency? Yes No

Malpractice Claims History

- 16 Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated)? Yes No
- If yes, please check this box and complete and submit Attachment G.

Criminal

- 17 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional? Yes No
- 18 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense? Yes No
- 19 Have you been court-martialed for actions related to your duties as a medical professional? Yes No

Ability to Perform Job

- 20 Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) Yes No
- 21 Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? Yes No

Ability to Perform Job

- 22 Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients? Yes No
- 23 Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation? Yes No

Please use the space on page 10 to explain yes answers to any question except #16.

Section III – Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with

(PLEASE INDICATE MANAGED CARE COMPANY(S) OR HOSPITAL(S) TO WHICH YOU ARE APPLYING) (HEREINAFTER, INDIVIDUALLY REFERRED TO AS THE "ENTITY")

LIBERTY DENTAL PLAN

and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

For Hospital Credentialing. I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third

APPLICANT'S INITIALS AND DATE (MM/DD/YYYY)

Section III – Standard Authorization, Attestation and Release – continued

party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

SIGNATURE

NAME (PLEASE PRINT OR TYPE)

Last 4 digits of SSN or NPI (PLEASE PRINT OR TYPE)

DATE (MM/DD/YYYY)

Required Attachments or Supplemental Information – Please attach hard copy or scanned documents of the following:

- Copy of DEA or state DPS Controlled Substances Registration Certificate
- Copy of other Controlled Dangerous Substances Registration Certificate(s)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant's name
- Copies of IRS W-9s for verification of each tax identification number used
- Copy of workers compensation certificate of coverage, if applicable
- Copy of CLIA certifications, if applicable
- Copies of radiology certifications, if applicable
- Copy of DD214, record of military service, if applicable

Reproduction of this form without any changes is allowed.

Notice About Certain Information Laws and Practices Pertaining to State Governmental Bodies (i.e. State Hospitals)

With few exceptions, you are entitled to be informed about the information that a state governmental body collects about you (i.e. a state hospital). Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However the state governmental body may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that the state governmental body correct information that it has about you that is incorrect. For information about the procedure and costs for obtaining information, please contact the appropriate state governmental body to which you have submitted this application.

***PROFESSIONAL QUESTIONS and ATTESTATIONS: (All questions must be answered)**

YES	NO	#	Instructions: Check Yes or No. Do not leave any questions unanswered. For each "YES" response, please provide a detailed explanation on the Supplemental Form. You may also attach your written response or additional supporting documentation to the application.
<input type="checkbox"/>	<input type="checkbox"/>	1.	In the past five (5) years, have you had any gaps of six (6) months or greater, where you did not work as a practitioner in this current discipline? If "YES", please provide the reason(s) for any gap(s) on a separate page. Please mark "NO", if any gaps occur between education and employment.
<input type="checkbox"/>	<input type="checkbox"/>	2.	Has your license(s) to practice in any jurisdiction(s), whether completed or still pending, ever been denied, limited, suspended, revoked, not renewed, or have you ever been placed under probation, subject to disciplinary action or have you voluntarily relinquished any item in anticipation of any of these actions?
<input type="checkbox"/>	<input type="checkbox"/>	3.	Has your professional liability insurance ever been denied, suspended, canceled, or subjected to any disciplinary action?
<input type="checkbox"/>	<input type="checkbox"/>	4.	Have any of your DEA or State Drug Certificate registrations ever been denied, suspended, canceled, or subjected to any disciplinary action?
<input type="checkbox"/>	<input type="checkbox"/>	5.	Has your status as a provider or membership with any professional organization, ever been denied, suspended, canceled, sanctioned, or subjected to any disciplinary action? Are you currently under investigation by any municipal, state, federal or any other government agency, HMO, PPO or other prepaid health plan? (e.g. Medicare, Medicaid)
<input type="checkbox"/>	<input type="checkbox"/>	6.	Are your privileges or memberships at any hospital or institution (military service) currently under investigation or have they ever been denied, suspended, reduced, disciplined, or not renewed?
<input type="checkbox"/>	<input type="checkbox"/>	7.	Are you prevented from performing any procedures within the scope of privileges and duties as a healthcare provider?
<input type="checkbox"/>	<input type="checkbox"/>	8.	Do you currently, or did you in the last five years, engaged in the unlawful use of drugs, including the improper use of prescription drugs, to include any physical, mental or substance abuse problems that could, without reasonable accommodation, impede the your ability to provide care, according to accepted standards of professional performance; or pose a threat to the health or safety of patients?
<input type="checkbox"/>	<input type="checkbox"/>	9.	Do you have any felony or misdemeanor charges pending against you, other than a traffic violation, or have you ever been convicted or pleaded "nolo contendere" to a felony?
<input type="checkbox"/>	<input type="checkbox"/>	10.	Have you been involved, within the last ten years, or are you currently involved in ANY claims/lawsuits, settlements, or judgments (other than divorce or custody)? If YES, please provide detailed information on a separate sheet of paper including: docket # of the case, location of the court, the names of the party plaintiff(s) and defendant(s), description and date(s) of the incidents(s), your involvement, current disposition, and the amount of settlement.
<input type="checkbox"/>	<input type="checkbox"/>	11.	Are you currently practicing WITHOUT, or with and EXPIRED, Professional Liability/Malpractice Insurance?
<input type="checkbox"/>	<input type="checkbox"/>	12.	Have you ever been reported to the National Practitioner's Data Base?

I hereby make formal application for network participation with LIBERTY Dental Plan.

*DOCTOR'S SIGNATURE: _____
(No Signature Stamps)

*DATE: ____ / ____ / ____

*PRINT NAME: _____

*LICENSE #: _____

*STATE: _____



Information Release / Acknowledgments:

I authorize **VerifPoint/CreDENTIALs** or any **LIBERTY Dental Plan contracted ("CVO")**, to consult with professional liability carriers and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics and other qualifications.

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (under "Credentialing Information") by and between LIBERTY Dental Plan and other Healthcare Organizations (e.g. hospital medical staff, medical groups, independent practice associations (IPA's), health plans, health maintenance organizations (HMO's), preferred provider organizations (PPO's), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, businesses and individuals acting as their agents (collectively, "HealthCare Organizations), for the purpose of evaluating this application and re-credentialing application regarding my professional training, experience, character, conduct, judgment, ethics, records and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patients' records and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluation the qualifications of healthcare providers. I hereby release all persons and entities, including LIBERTY Dental Plan and its agent(s), engaged in quality assessment, peer review and credentialing on behalf of LIBERTY Dental Plan, from an liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation with LIBERTY Dental Plan, to the extent that those acts and/or communications are protected by state and federal law.

I, the undersigned, hereby certify that the information requested by the CVO is truthful, correct and complete in all respects and I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating provider with the affiliated organization contracted with the CVO. The undersigned hereby agrees to notify the CVO of any changes in the above information.

I understand that if LIBERTY Dental Plan denies my application or otherwise takes action that is adverse to my request for participation, LIBERTY Dental Plan and/or its Representatives may be obligated, under applicable law, to report such action to the National Practitioner Data Bank and/or other licensing or accreditation agencies.

***DOCTOR'S SIGNATURE:** _____
(No Signature Stamps)

***DATE:** ____ / ____ / ____

***PRINT NAME:** _____

