

Texas Dental Credentialing Application

Texas Dental Credentialing Application

Provider Information				
First Name:	MI:	Last Name:	Suffix (Jr., Sr., etc.):	<input type="checkbox"/> Male <input type="checkbox"/> Female
Other Name(s) Used/Name as Appears on Dental Degree:		DOB (MM/DD/YY): ____/____/____	Specialty: <input type="checkbox"/> Dental Assistant <input type="checkbox"/> Dental Hygienist <input type="checkbox"/> Denturist <input type="checkbox"/> Doctor of Dental Surgery <input type="checkbox"/> Doctor of Dentistry <input type="checkbox"/> Dental Anesthesiology	
SSN: - -	NPI-Type1:	<input type="checkbox"/> Owner <input type="checkbox"/> Assoc. <input type="checkbox"/> Employee <input type="checkbox"/> MD <input type="checkbox"/> DDS <input type="checkbox"/> DMD		
Email	Medicare Number	<input type="checkbox"/> Endodontic Dentist <input type="checkbox"/> Oral Pathology <input type="checkbox"/> Oral Radiology <input type="checkbox"/> Orthodontic Dentist <input type="checkbox"/> Pediatric Dentist <input type="checkbox"/> Periodontic Dentist <input type="checkbox"/> Prosthodontic Dentist		
Licensing Information <i>including current license(s) and history of licensure in all jurisdictions.</i> Please attach current copy copies with application.				
State License Number:		State:	Effective Date: ____/____/____	Expiration Date: ____/____/____
State License Number:		State:	Effective Date: ____/____/____	Expiration Date: ____/____/____
DEA Number:	DEA Release:	State:	Expiration Date: ____/____/____	<input type="checkbox"/> Not Applicable
CDS Number:		State:	Expiration Date: ____/____/____	<input type="checkbox"/> Not Applicable
Refer to emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Education/Training				
Dental School Name:				Degree:
Graduation Mo/Yr.:		Attended From ____/____/____ To ____/____/____		
Address:		City:	State:	County:
Residency/Specialty Training Institution Name:			Program/Training Type:	
Graduation Mo/Yr.:		Attended From ____/____/____ To ____/____/____		
Address:		City:	State:	
Board Certified: Yes No	Certifying Board Name:		Certification Date:	
Specialty:				
Dental Training Outside US:				
Are you an American board-certified diplomat? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Work History <i>Include work history for the past 10 years. Beginning with the most recent.</i>				
Employer	Address (City, State)		Month/Year Started	Month/Year Ended
			____/____	____/____
			____/____	____/____
			____/____	____/____
			____/____	____/____
Explain any gap in work history greater than 6 months.				
Professional Liability Insurance <i>Required: attach a current copy of your malpractice insurance declaration page.</i>				
Professional Liability Insurance Carrier			Policy No.	
Policy Effective Date (MM/DD/YY): ____/____/____	Policy Expiration Date (MM/DD/YY): ____/____/____	Occurrence Limit (per claim):	Aggregate Limit:	
General Liability Insurance <i>Please attach a current copy of your malpractice insurance declaration page.</i>				
General Liability Insurance Carrier			Policy No.	
Policy Effective Date (MM/DD/YY): ____/____/____	Policy Expiration Date (MM/DD/YY): ____/____/____	Occurrence Limit (per claim):	Aggregate Limit:	
Hospital Affiliations <i>If not applicable, check here</i>				
Hospital Name	Address (City, State)		Privileges	Affiliation End date
				____/____
Practice Information Please note: Providers may only have four locations listed on provider directory portal. Attach list of additional locations as applicable.				

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Primary Practice Name:					Start Date (MM/DD/YY): ____/____/____		
Practice Address:				City:		State:	Zip:
County:			Business URL:				
Practice Phone No.: ()		Practice Fax No.: ()		Tax ID (Please submit W-9)		NPI No. (Type 2/Organization) or Sub-part:	
Is Correspondence Address (if different from primary):					Practice Type <input type="checkbox"/> Clinic <input type="checkbox"/> School <input type="checkbox"/> Hospital <input type="checkbox"/> Academic Dental Center <input type="checkbox"/> Multi Specialty Group <input type="checkbox"/> Single Specialty Group <input type="checkbox"/> County <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Mobile Unit <input type="checkbox"/> FQHC <input type="checkbox"/> RHC <input type="checkbox"/> CHC <input type="checkbox"/> Other:		
Billing Address (if different from primary):							
Credentialing Contact:			Email Address:		Phone No.: ()		
Practice hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Provider hours at Practice	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Publish on Directory <input type="checkbox"/> Yes <input type="checkbox"/> No		Publish on Web Portal <input type="checkbox"/> Yes <input type="checkbox"/> No			Are translation services available? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have your staff completed cultural competency training? <input type="checkbox"/> Yes <input type="checkbox"/> No				Does your office provide access to a skilled medical interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No			
After Hours Coverage							
Special Needs Patients Do you accept special needs patients? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, check all that apply:							
<input type="checkbox"/> ADHD	<input type="checkbox"/> End stage renal disorder	<input type="checkbox"/> Chronic illness	<input type="checkbox"/> Physical disability	<input type="checkbox"/> HIV			
<input type="checkbox"/> AIDS	<input type="checkbox"/> Learning disabled and learning problems	<input type="checkbox"/> Cultural competency training	<input type="checkbox"/> Serious mental illness	<input type="checkbox"/> Other	<input type="checkbox"/> Sedation services for members with complex medical or behavioral conditions <input type="checkbox"/> Visually impaired		
<input type="checkbox"/> Child	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Difficulty communicating	<input type="checkbox"/> Adult and child	<input type="checkbox"/> Behavioral disorders			
<input type="checkbox"/> Cognitive disability	<input type="checkbox"/> Seizure disorders	<input type="checkbox"/> Hearing impaired	<input type="checkbox"/> Co-existing disorders	<input type="checkbox"/> Deafness			
<input type="checkbox"/> Development disabilities	<input type="checkbox"/> Adult	<input type="checkbox"/> Mobility limitations	<input type="checkbox"/> Duals demonstration				
Age range of special needs patients Age from _____ Age to _____		Is your office on or near a public transportation line? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is your office handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		Handicap Parking Available? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you able to treat wheelchair confined patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Accepts new patients <input type="checkbox"/> Yes <input type="checkbox"/> No		Age of patients: from _____ to _____			
Second Practice Address							
Second Practice Name:					Start Date (MM/DD/YY): ____/____/____		
Second Practice Address:				City:		State:	Zip:
County:			Business URL:				
Practice Phone No.: ()		Practice Fax No.: ()		Tax ID (Please submit W-9)		NPI No. (Type 2/Organization) or Sub-part:	
Is Correspondence Address (if different from primary):					Practice Type <input type="checkbox"/> Clinic <input type="checkbox"/> School <input type="checkbox"/> Hospital <input type="checkbox"/> Academic Dental Center <input type="checkbox"/> Multi Specialty Group <input type="checkbox"/> Single Specialty Group <input type="checkbox"/> County <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Mobile Unit <input type="checkbox"/> FQHC <input type="checkbox"/> RHC <input type="checkbox"/> CHC <input type="checkbox"/> Other:		
Billing Address (if different from primary):							
Credentialing Contact:			Email Address:		Phone No.: ()		
Practice hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Provider hours at Practice	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Publish on Directory <input type="checkbox"/> Yes <input type="checkbox"/> No		Publish on Web Portal <input type="checkbox"/> Yes <input type="checkbox"/> No			Are translation services available? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have your staff completed cultural competency training? <input type="checkbox"/> Yes <input type="checkbox"/> No				Does your office provide access to a skilled medical interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Special Needs Patients Do you accept special needs patients? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, check all that apply:							

<input type="checkbox"/> ADHD	<input type="checkbox"/> End stage renal disorder	<input type="checkbox"/> Chronic illness	<input type="checkbox"/> Physical disability	<input type="checkbox"/> HIV
<input type="checkbox"/> AIDS	<input type="checkbox"/> Learning disabled and learning problems	<input type="checkbox"/> Cultural competency training	<input type="checkbox"/> Serious mental illness	<input type="checkbox"/> Other
<input type="checkbox"/> Child	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Difficulty communicating	<input type="checkbox"/> Adult and child	<input type="checkbox"/> Sedation services for members with complex medical or behavioral conditions
<input type="checkbox"/> Cognitive disability	<input type="checkbox"/> Seizure disorders	<input type="checkbox"/> Hearing impaired	<input type="checkbox"/> Behavioral disorders	<input type="checkbox"/> Visually impaired
<input type="checkbox"/> Development disabilities	<input type="checkbox"/> Adult	<input type="checkbox"/> Mobility limitations	<input type="checkbox"/> Co-existing disorders	
	<input type="checkbox"/> Autism		<input type="checkbox"/> Deafness	
			<input type="checkbox"/> Duals demonstration	

Age range of special needs patients Age from _____ Age to _____	Is your office on or near a public transportation line? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your office handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Handicap Parking Available? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are you able to treat wheelchair confined patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accepts new patients <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of patients: from _____ to _____
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Professional Questions and Attestation Release (Not for Use for Employment Purposes)

1.	In the last five (5) years, have you had any gaps greater than six (6) months, where you did not work as a practitioner in this current discipline? If "YES," please explain the reason(s) for any gap(s) on a separate page.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Have there ever been any actions against or investigations relating to your professional license(s) in any jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you ever voluntarily or involuntarily surrendered your license?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Have you ever been named in any malpractice action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Does your current liability malpractice insurance coverage exclude any specific procedures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Have you been without malpractice insurance coverage in the past five consecutive years? (For healthcare Practitioners in the Commonwealth of Massachusetts: Have you been without malpractice insurance coverage in the past ten consecutive years?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Has your professional liability insurance coverage ever been denied, suspended, restricted, limited, modified, canceled or not renewed by the action of any insurance company?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Have you ever been convicted of a felony, including, but not limited to, fraud, narcotics, or crimes involving children? (Misdemeanors do not need to be reported.) This statement is being answered under the penalty of perjury, subject to applicable Federal punishment for perjury. If yes, please include the disposition of the arrest or charge and explain all such occurrences in an attachment.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Have you ever been named as a defendant in any past or pending criminal proceedings including misdemeanors (excluding traffic violations)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Are you prevented from performing any procedures within the scope of privileges and duties as a healthcare provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Have you ever voluntarily or involuntarily surrendered membership in a professional organization/association?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, 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 record 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?*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Has there ever been any disciplinary action, suspension, probation, formal reprimand or request to voluntarily or involuntarily resign during your education, internship, residency, fellowship, preceptorship, or additional applicable training?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	Has there ever been any action against or investigation relating to your board certification (e.g. medical professional board / society) or have you voluntarily or involuntarily surrendered any board certifications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15.	Has an adverse action been filed against you or have you received any disciplinary procedures regarding your participation in any private, state, or federal insurance program including Office of Personnel Management, Medicare, Medicaid or TRICARE?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16.	Is there any physical, mental, or substance abuse problems that would prevent you from being able to completely perform essential job-related functions, without risk to patient safety or health, with or without reasonable accommodation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17.	Are you currently using any illegal substances or are you chemically dependent on alcohol, drugs, or illegal substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered "yes" to any of the above questions, please explain, in detail, on the Affirmative Answer Explanation(s) page.

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Affirmative Answer Explanation(s)

_____ Question Number

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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, membership and/or clinical privileges (referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as "Entity"), and any of 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 my application for Participation with the Entity is not an application for employment and that acceptance of my application will not result in my employment by the Entity.

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 agent(s); and the Entity's designated professional credentials verification organization (collectively "Agents"), to investigate information, which includes 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 and copy 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 any and all information requested in furtherance of the credentialing process, including, but not limited to: my history of claims that have been made and/or are currently pending against me; and, any coverage details, including declaration sheet(s). 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 conclusion of any disciplinary proceedings or prior to commencement of formal charges, but after I have knowledge that 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 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 current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) 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 online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. 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 and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature

Name (Printed)

Date Signed

Required:

This Application is authorized for use by the following dental plans:

- MCNA
- DentaQuest
- UHC Dental

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Required Attachments:

- Malpractice Insurance – CURRENT Certificate of Insurance Attached
ATTENTION: If your current Malpractice Insurance is EXPIRING in the next 30 days or less - NEW copy of Malpractice Insurance Attached
- Additional Location Page Attached
- Additional Licensure Information Attached
- Attach all applicable Sedation/ Anesthesia Permits and Licenses
- Disclosure Statement if applicable