

Please use the checklist below to ensure that we have all of the information we need to process your application efficiently.

Be sure that:

- All sections** of the form are filled out completely.
- Your personal date of birth, social security number (SSN) and Individual NPI** are included. We cannot accept your application without these numbers.
- Location Distinction has been selected** for each location.

- Primary:** Dentist has a set/regular schedule available for patient care. (Name/location will appear in directory).
- Secondary:** Dentist does **NOT** have a set/regular schedule **but** may infrequently provide care at location. (Claims will be processed as in-network).

- Both Email Addresses have been provided** for each location:

- Email for Public Directory:** This is an email address Patients can use to communicate with the Location. This address will appear in our online directory.
- Email for Correspondence:** This is an email address that Principal would use to communicate any Contractual & Compliance matters, Notices, &/or Surveys. This address is **not** shared.

- The ID number you use to submit claims** (your SSN or tax identification number (TIN) is included for each location.)
- Thorough explanations** are given for any “yes” answers to Questions 1–8 and any “no” answers to Questions 9–10.

Questions 1-8, if “yes”, please explain for each suit, arbitration, or settlement (whether open or closed) all details including dates of incidents, filings, settlements; underlying circumstances; your role and legal status (defendant, co-defendant, other); subsequent events (including patient outcome); professional liability insurer involved; amounts paid, and current status.

- Your signature** appears on the Principal Life Dentist Information Form.
- You have included clear and legible** copies of the following documents:
 - Current State(s) License**, showing expiration date.
 - Specialty Diploma**, if applicable.
 - Current Federal DEA Certificate**, if you prescribe drugs and as applicable. Or letter of coverage/explanation
 - Professional Liability Insurance** (not general) page(s), showing name and address of carrier, individuals covered, expiration date, and liability limits.
 - Individual NPI**, provide verification
 - Organization NPI**, provide verification, if applicable
 - Tax Identification Number (TIN)**, provide **one**: CP 575, 147C, or W9 with effective date.
 - Two letters of reference, recommendation, &/or letters of oversight from supervisor**, NC applicants only

If you have questions or need additional forms, please contact:

Phone Number:

Fax:

Email:



(PLEASE PRINT CLEARLY OR TYPE)

Dentist Information - Your Date of Birth, SSN and NPI are required.

Name as it appears on state license

First: _____ Middle: _____ Last: _____ Suffix: _____
 Other name(s) currently or previously used: _____ Gender: Male Female Non-Binary
 Date of Birth: _____ SSN: _____ Individual NPI: _____
 Languages Spoken by Dentist (other than English): _____

Location Information

Location 1 – Start Date at this location: _____ Location is: Primary Secondary
 DBA/Practice Name (As shown on W9 Line 2): _____
 Street: _____ Suite: _____
 City: _____ State: _____ Zip: _____
 Phone: (____) _____ Fax: (____) _____
 Email for Public Directory: _____
 Email for Correspondence: _____
 Organization/Type II NPI: _____ Claims submitted: Electronically Paper
 SSN or TIN for IRS Reporting: _____ – _____ Type: SSN TIN
 Billing Name (As shown on W9 Line 1): _____
 Billing Address (As shown on W9 Line 5 & 6): _____ Same as Above
 Office Hours (ie, M 8:00-5:00pm, Tu Closed, etc): _____
 Do you have 24 hour coverage? Yes No Is the location handicap accessible? Yes No

Location 2 – Start Date at this location: _____ Location is: Primary Secondary
 DBA/Practice Name (As shown on W9 Line 2): _____
 Street: _____ Suite: _____
 City: _____ State: _____ Zip: _____
 Phone: (____) _____ Fax: (____) _____
 Email for Public Directory: _____
 Email for Correspondence: _____
 Organization/Type II NPI: _____ Claims submitted: Electronically Paper
 SSN or TIN for IRS Reporting: _____ – _____ Type: SSN TIN
 Billing Name (As shown on W9 Line 1): _____
 Billing Address (As shown on W9 Line 5 & 6): _____ Same as Above
 Office Hours (ie, M 8:00-5:00pm, Tu Closed, etc): _____
 Do you have 24 hour coverage? Yes No Is the location handicap accessible? Yes No

FOR ADDITIONAL LOCATIONS, PLEASE COPY/COMPLETE THIS PAGE

Dentist Education and Training

Field of practice: General Dentistry Orthodontics Pediatric Dentistry Oral Maxillofacial Surgery
 Endodontics Prosthodontics Periodontics Dental Anesthesiologists

Dental school: _____ Month/Year graduated: _____

Specialty training institute: _____ Month/Year completed: _____

Professional Degree(s): _____ Board certified? Yes No

Do you have hospital privileges? Yes No **If yes, complete the following:**

Hospital name: _____ Phone number: _____

Address: _____ City: _____ State: _____ ZIP: _____

Dentist Licensing – Required: List ALL your license history. (Attach separate sheet if necessary)

License No. _____ State: _____ Years (to/from): _____

License No. _____ State: _____ Years (to/from): _____

License No. _____ State: _____ Years (to/from): _____

DEA No. _____ State: _____ Expiration Date: _____

Applied for a DEA, awaiting approval No DEA, I do not prescribe controlled substances

Work History – Required: List all your current and previous dentistry-related work and school experience for the **LAST 5 YEARS**. Include residency or fellowship, as applicable. (Attach separate sheet if necessary)

Attaching Curriculum Vitae (CV), in lieu of listing

Previous practice name, experience residency, etc: _____

Location (city and state): _____

Start date (month/year): _____ End date (month/year): _____

Previous practice name, experience residency, etc: _____

Location (city and state): _____

Start date (month/year): _____ End date (month/year): _____

Previous practice name, experience residency, etc: _____

Location (city and state): _____

Start date (month/year): _____ End date (month/year): _____

Licensing / Confidential Info – Required: Please explain any “yes” answers to Questions 1-8 & “no” answers to Questions 9 & 10. **DENTIST SHOULD COMPLETE THIS SECTION TO ENSURE ACCURACY.**

Yes No 1. Are you now or have you ever been involved in any malpractice suit or arbitration, or has any settlement ever been paid by you or paid on your behalf?

Yes No 2. Has your professional liability insurance ever been denied, suspended, canceled or not renewed?

Yes No 3. Have you ever had any of the following items denied, revoked, suspended, not renewed, placed on probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?

Yes No State license

Yes No DEA, CDS, or other applicable narcotic registration

Yes No Hospital or other health-care facility staff membership or privileges

Yes No Professional organization membership

Yes No Medicaid or other government program participation

Yes No HMO, PPO, or other managed care plan

Yes No Employment as a health-care provider by a military service, hospital, HMO, or other health-care organization

- Yes No 4. Do you have any physical or mental impairment or condition that, with or without accommodation, would make you unable to perform the essential functions of a practitioner in your area of practice or unable to perform such essential functions without a direct threat to the health and safety of others?
- Yes No 5. Considering the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that could pose a significant health and safety risk to your patients?
- Yes No 6. Within the past five years up to and including the present, have you ever had a chemical dependency or substance abuse problem that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?
- Yes No 7. Have you ever been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime?
- Yes No 8. Have you ever been subject to any peer-review type of action?
- Yes No 9. Does your office utilize proper infection control and barrier techniques?
- Yes No 10. Does your office comply with OSHA requirements?

Question Explanation – Use this space or a separate sheet to explain any “yes” answers to Question 1-8 and any “no” answers to Questions 9-10.

Authorizations and Releases - Required

I authorize Principal Life and its clients to obtain information from others including state licensing authorities, certification boards, professional liability insurance carriers (including claim histories and loss reports), hospitals, substance-abuse programs, and health-care-related employers, about my qualifications, including without limitation, my professional competence and conduct. I further authorize, Principal Life and its clients, to release information on this form to their parent organizations, affiliates, subsidiaries, employees, and agents.

I consent to the release to Principal Life's Credentialing Verification Organization (CVO) 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 release the CVO and any persons or entities providing information to the CVO or evaluating the information received or provided on this form, from any and all liability, providing their acts were performed in good faith and without malice.

I understand I have the burden of providing adequate information to the CVO to demonstrate my qualifications. I understand and agree that any misstatement or material omission on this form may constitute grounds for rejection of my application or dismissal as a member or participating provider with the CVO or its client-sponsored networks. I understand and agree that it is my obligation to immediately notify the CVO if any material changes occur in the information I have provided on this form.

I understand that statements written on this form will be considered statements made by me, even if prepared by an employee, agent, or representative.

I attest that the information contained on this form is correct and complete.

Dentist's name (please print): _____

Dentist's signature (original signature only – no stamps): _____

Date: _____

If we have any questions or need additional information, Contact person completing this form:

Name: _____

Phone: _____

E-mail: _____