

CREDENTIALING APPLICATION

This Credentialing Application cannot be processed until it is completed in FULL.
Please maintain a copy of this Credentialing Application for your records.

Credentialing Application is complete when:

- The Credentialing Application has been updated in its entirety, signed and dated**
(NO STAMPED SIGNATURES)
- Current Copies** of the following have been **attached**:
 - Dental License** (provide copies for EVERY state in which you are licensed)
 - Federal DEA Registration** for **EVERY STATE** the DDS is participating in (or documentation DEA is pending or who will be prescribing on provider's behalf)
 - American Board Certificate** (if applicable)
 - Institution Specialty Certificate** (if applicable)
 - Professional Liability / Malpractice Insurance Declaration Page** – showing minimum malpractice insurance coverage of \$1 million/\$3 million, dentist's name, policy #, effective and expiration dates.
 - If expiration date** is within weeks of this application, updated documentation must be submitted.
- W-9 Form or Taxpayer Identification Number Request**
 - IRS Name as registered with the IRS**
 - Signed and dated within the last 12 months**
 - One number (either EIN or SSN)**

Please attach a signed contract for network participation:

- Dentist Participation Agreement(s)

MAIL CREDENTIALING APPLICATION TO:

Dental Network Services
PO Box 640
Minneapolis, MN 55440

OR
FAX: (866) 286-8840

QUESTIONS? Call (toll free) (866) 947-9398

Notice of Applicant's Right

You may review or request the status of your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable State laws. If there are discrepancies in the information received during the credentialing process, you will be notified and allowed an opportunity to correct erroneous information submitted by another party within thirty (30) days of submitting your application. This includes information submitted by an outside primary source, such as Professional Insurance Carrier, State License Board and/or the National Practitioner Data Bank.

Confidentiality Statement

Information gathered as part of the credentialing or re-credentialing process is maintained in a confidential manner and will not be communicated or reproduced. This provision is designed to safeguard information and ensure confidentiality.

DDS NAME AND STATE DENTAL LICENSE NUMBER (As indicated on your license copy):

PRIMARY PRACTICE LOCATION If more than one location please attach a separate sheet with the below information.

List the number of locations you would like to participate at: _____	<input type="checkbox"/> Owner <input type="checkbox"/> Partner <input type="checkbox"/> Associate
Doing Business As Name: _____	
Street Address (Building; Street; Suite #): _____	
City/State/Zip: _____ County: _____	
Office Phone Number: (_____) _____ ER/After Hours Number: (_____) _____	
Fax Number: (_____) _____	
Office Email: _____	
	Email Address available for patients if different than above: _____
Tax ID Number (TIN): AS LISTED ON W-9 _____	
Type 2 NPI: _____	Clinic: _____ Corporate: _____
Office Manager/Contact: _____	
Credentialing Contact: _____	
Are office protocols for infection control in compliance with current CDC/OSHA guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Language Information - List any languages spoken by the applicant

English () Yes No ()

Do you have a non-English language qualified medical interpreter employed in your practice () Yes () No
 If yes:

- Has qualified medical interpreter successfully completed a medical interpretation program () Yes () No
- When was the program completed _____ (MM/YYYY)
- Name of qualified medical interpreter _____
- List the non-English languages that person is qualified to interpret: _____

<p>CORRESPONDENCE INFORMATION: (If different from primary practice location) This address is used to send communications such as welcome letters and newsletters</p>	<p>BILLING INFORMATION: (If different from primary practice location) This address is for claim reimbursement</p>
Address: _____ _____ _____	Address: _____ _____ _____

DISCLOSURE QUESTIONS

Please complete the Professional Liability Addendum if any question(s) are answered in the affirmative.

1. Yes No **Have you ever** had your **professional license, registration or DEA** terminated, stipulated, restricted, limited, conditioned, subjected to corrective action, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?
2. Yes No **Have you ever** had your **membership, participation, clinical privileges, or employment** denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?
3. Yes No **Have you ever** voluntarily/involuntarily relinquished your **membership, participation, clinical privileges or request for privileges, employment, professional license, or registration** as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?
4. Yes No **Have you ever** been reprimanded, censored, or otherwise disciplined by, or have you been subject to a corrective action agreement/plan with any **licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**
5. Yes No **Have you ever** had your certificate or participation in **any private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?
6. Yes No Are there any **charges pending or have you ever** been indicted, found guilty of a felony, misdemeanor (other than minor violations), or other offenses involving fraud, misrepresentation, dishonesty or deceit? Are you currently using illegal drugs?
7. Yes No **Have you ever** been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment?
8. Yes No **Have you ever** had any Malpractice (Professional Liability) claims or lawsuits brought against you, including pending, dismissed or dropped claims/lawsuits, settlements or final judgments? (This includes status of any pending claims previously reported.)
9. Yes No **Have you ever** had your Malpractice (Professional Liability) carrier refuse or cancel your coverage?
10. Yes No Do you have a condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing a significant health or safety risk to your patients?

DISCLOSURE QUESTIONS & PROVIDER CONSENT

I hereby certify that to my knowledge that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary while my application is being processed. I agree to notify any changes in malpractice coverage, including changes in the insurance carrier or policy number, as they occur.

By completing this application to become a participating provider, I fully understand that any significant misstatement in, or omission from, my application to become a participating provider may constitute cause for denial of my application or the subsequent termination of my participating provider contract if my application is accepted. I understand and agree that this consent is irrevocable for any period during which I am a participating provider. Reserved is the right to base acceptance into any individual network based on criteria established.

I understand that my application may require review of information related to me on file with other entities, including but not limited to, state licensing boards, specialty boards, professional societies, malpractice carriers, and the National Practitioner Data Bank administered by the U.S. Government.

I authorize release from liability all representatives, including any agent, my state licensing board, clinics, other institutions, professional societies, professional malpractice insurance carrier(s) and any staff, for their acts performed in good faith and without malice in connection with the gathering and exchange of information as consented above or to release information as required by State or Federal laws, rules, or regulations.

I understand and agree that I have the responsibility of producing adequate information for proper evaluation of my continued professional competence, ethics and other qualifications and for resolving any doubts about such qualifications. I further understand and agree that I have a continuing affirmative duty to immediately inform of any future restrictions or revocation of my professional license, any disciplinary action, suspension or voluntary/involuntary limitation, denial of my clinical or other privileges, or any other event which may adversely reflect upon my professional competence, ethics and other qualifications as a participating provider.

I understand that subject to proper confidentiality restrictions and authorizations, my dental records will be subject to inspection for quality assurance and utilization review purposes.

Signature _____ **Date** _____

Name _____ **Dental Lic #:** _____

(Please print or type)

(As it appears on your paper copy from state)

Complete this form if you answered "YES" to any Disclosure Questions
 Attach separate sheet if necessary

Malpractice Claim(s) or Board Action(s)

Type of action: Suspension Revocation Probation Stipulation & Order Conditional License Malpractice Settlement
 Other: _____

Current status of license: _____ Felony charge: Yes No

Date of occurrence: _____ Settlement or fine amount: _____ Date of settlement or action: _____

Action reported on: Office of Inspector General or System for Award Management: Yes No NPDB: Yes No

Current Status of Claim or action: Settled Closed Pending Dismissed Other: _____

If action was taken by the a Dental Board, please explain specific conditions of the order and include progress with order and include proof from the State Dental Board or entity that the action is satisfied (example, completed course work, length of probation etc):

Details of case or action:

Type of action: Suspension Revocation Probation Stipulation & Order Conditional License Malpractice Settlement
 Other: _____

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Details of case or action:

Employment History Addendum

Dates (mm/yy)	Facility and Address	Phone Number & TIN
From: _____ To: _____ Present		
Reason for gap:		
From: _____ To: _____		
Reason for gap:		