

Credentialing Application

INSTRUCTIONS FOR COMPLETING THE APPLICATION	<p>Please answer all questions completely and fully. If something is not applicable, please indicate N/A. If more space is required, attach additional sheets and reference the question being answered. Incomplete applications cannot be processed and will delay the credentialing process.</p> <p>Once completed, see the last page of this application for methods of submission.</p> <p>To check the status of your application or to request copies of information retained in your provider record, please call (800) 307-8514.</p>
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SECTION I – PERSONAL INFORMATION

Last Name	First Name	MI	Suffix
Previous Name Used (if applicable)		Professional Degree (DDS, DMD, etc.)	
DOB (MM/DD/YY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN (for identification and verification purposes)	
Languages Spoken (other than English) <input type="checkbox"/> Arabic <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Hindi <input type="checkbox"/> Korean <input type="checkbox"/> Persian <input type="checkbox"/> Pilipino/Tagalog <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____		<i>If you are not a US Citizen, do you have authorization to work in the US?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

SECTION II – CURRENT PRACTICE INFORMATION

Attach a list of additional dental facilities where you currently practice, beginning with the most recent (if applicable).

Practice Name	Office Phone	Office Fax
Street Address	City/ST/Zip	
County	Email - Please supply us with the appropriate email address to be used for each of the following types of communication:	
Mailing Address (if different from Practice Address)	Provider Notifications: _____ Credentialing Requests: _____ Patient Communication: _____	
County	<input type="checkbox"/> Check to confirm that you agree with the following: I verify that the email address is intended for patient communication, is regularly monitored, and maintained in a manner consistent with state and federal health privacy laws.	
Is the office accessible by public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is handicapped parking available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your office handicapped accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is off street parking available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you treat adult s with special needs? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you treat children with special needs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Federal TIN #	TIN Name	Which # should be used for Federal 1099 Tax Requirements? NOTE: A valid copy of your W-9 is required. <input type="checkbox"/> SSN <input type="checkbox"/> EIN
Do you have a National Provider Identifier (NPI) #? <input type="checkbox"/> Yes <input type="checkbox"/> No	NOTE: If yes, a copy of your National Plan and Provider Enumeration System confirmation is preferred.	Master Provider Index (MPI) – DHS Access # (Include a separate number for each practice location)
NPI Entity Type 1 #	NPI Entity Type 2 #	Medicare #
Will you accept new patients from our HMO Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will you accept new patients from our PPO Plan(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	What are your treatment age limitations? <input type="checkbox"/> None Min. Age _____ Max. Age _____

SECTION III – LICENSE INFORMATION

Provide the following information for each state in which you are currently or were previously licensed to practice. If there is not enough space, attach an additional sheet.

State	Date of License (MM/DD/YYYY)	License #	Status <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Suspended	Expiration Date (MM/DD/YYYY)
State	Date of License (MM/DD/YYYY)	License #	Status <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Suspended	Expiration Date (MM/DD/YYYY)
State	Date of License (MM/DD/YYYY)	License #	Status <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Suspended	Expiration Date (MM/DD/YYYY)
State	Date of License (MM/DD/YYYY)	License #	Status <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Suspended	Expiration Date (MM/DD/YYYY)
Do you have a State Drug Registration? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide State Drug Registration # Expiration Date (MM/DD/YYYY)		<input type="checkbox"/> If no, I agree that prescribing any scheduled drugs is not within the scope of my practice. Should the need arise, I attest that a participating practitioner with a valid CDS permit will write all prescriptions requiring a CDS number.
Do you have a DEA Certificate/License? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide DEA Certificate/License # Expiration Date (MM/DD/YYYY)		
Do you have an Anesthesia/Analgesia License? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide Anesthesia/Analgesia License #		Expiration Date (MM/DD/YYYY)

If yes, indicate the Anesthesia Type(s)
 Conscious Sedation Enteral Sedation General Anesthesia Nitrous Oxide

NOTE: A copy of all applicable license(s) is preferred.

SECTION IV – PROFESSIONAL LIABILITY MALPRACTICE INSURANCE

Malpractice Carrier	Policy Number	Expiration Date
Coverage Amounts (per occurrence/aggregate)		

NOTE: A copy of your current professional liability malpractice coversheet is required and the following items MUST be included: applicant's name, coverage amounts, effective and expiration dates.

SECTION V – EDUCATION

Dental School (Do not abbreviate the school's name.)	Graduation Date (MM/YY)	
Did you complete a Residency Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, indicate the facility name	Completion Date (MM/YY)
If yes, indicate the residency City/ST/Zip		
Specialty <input type="checkbox"/> General Dentist <input type="checkbox"/> Endodontist <input type="checkbox"/> Oral/Maxillofacial Surgeons <input type="checkbox"/> Orthodontist <input type="checkbox"/> Pedodontist/Pediatric Dentist <input type="checkbox"/> Periodontist <input type="checkbox"/> Prosthodontist		
Specialty Board Status (American Board Only) - NOT APPLICABLE FOR GENERAL DENTISTS <input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible <input type="checkbox"/> Not Board Eligible		

NOTE: A copy of your clinical residency certificate is required for specialists who indicate board eligible or not board eligible above.

SECTION VI – OFFICE HOURS

Monday	Tuesday	Wednesday	Thursday
Friday	Saturday	Sunday	

SECTION VII – WORK/PRACTICE HISTORY

List any private practice affiliations or other employment since completion of dental school or in the past 5 years (whichever is less) and current practice location below. You may also submit a Curriculum Vitae as a supplement.

Please provide a written explanation for any time period of more than 6 months not covered by any affiliation or training.

Practice Name	Street	City/ST/Zip	Employment Date - From/To (MM/YY)
Practice Name	Street	City/ST/Zip	Employment Date - From/To (MM/YY)
Practice Name	Street	City/ST/Zip	Employment Date - From/To (MM/YY)
Practice Name	Street	City/ST/Zip	Employment Date - From/To (MM/YY)

SECTION VIII – HOSPITAL AFFILIATION (if applicable)

Do you have a hospital affiliation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what are your privileges? <input type="checkbox"/> Courtesy <input type="checkbox"/> Active
If yes, indicate the hospital name and address	If yes, indicate the dates of the affiliation (from MM/YY to MM/YY)

SECTION IX – ATTESTATION QUESTIONS

An explanation for any attestation questions answered yes must be submitted with this application.
The explanation should include the dates, amounts, outcome and signature of the applicant.

	YES	NO
1. Do you have any pending malpractice, civil, or criminal claims against you or are you currently the subject of an investigation by any licensing authority, DEA or CMS entities, hospital, education or training program, Medicare or Medicaid program or any other federal or state health programs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you currently aware of any malpractice, civil, or criminal allegations that could lead to a malpractice suit, civil suit or criminal action against you?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any malpractice carrier made an out of court settlement or paid a Professional Liability claim on your behalf in the past five years or within the past ten years for the SmileNet Network only, or has any payment to resolve or avoid any allegation(s) concerning your competence, conduct or quality of care (not involving litigation, arbitration, or mediation) ever been paid by you or on your behalf?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your Professional Liability Insurance ever been denied, suspended, revoked, canceled or not renewed in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had a change of status in your Dental License(s), Hospital Privileges, Board Certification, or Federal or State Narcotics License(s)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has a governmental agency, including a state licensing board, ever investigated you, suspended, revoked or taken any other action against either your Narcotic(s) Licenses or License(s) to practice dentistry?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have any Medicare/Medicaid charges ever been filed against you, or has your participation in any government programs ever been denied, suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been the subject of an investigation, indicted for, convicted of, or pleaded “no contender” to a misdemeanor (other than a traffic violation), felony, moral or ethical crime, including fraud, an act of violence, child abuse, a sexual offense or sexual misconduct, or are you under investigation for such conduct?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has your status as a provider, or membership in any professional organization, ever been denied, suspended, revoked, disciplined, cancelled, sanctioned, or are you currently under investigation by any municipal, state, federal or any other governmental agency, HMO, PPO or other prepaid health plans (e.g. Medicare or Medicaid)?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been convicted for use, possession or sale of illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you currently, or did you in the past two years, engage in the unlawful use of illegal drugs, including improper use of prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors or treats you?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have any limitations, including those which could risk the safety or the well-being of your patients, for which reasonable accommodation is necessary in order to perform the essential and/or marginal duties of your job?	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you employed by the United States Government?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION X – ATTESTATION RELEASE

I acknowledge and agree that United Concordia Companies, Inc. has a valid interest in obtaining and verifying information concerning my professional competence in determining whether to enter into an agreement with me for the provision of dental services to members of the affiliated prepaid dental care plans. Accordingly,

- (i) I attest to United Concordia Companies, Inc. that the information obtained in the attached application is true and complete to the best of my knowledge. I agree to inform United Concordia Companies, Inc. promptly if any material change in such information occurs, whether before or after my entering into an agreement with United Concordia Companies, Inc. for the provision of dental services.
- (ii) I hereby consent to the release to United Concordia Companies, Inc., of any information which may reasonably be considered relevant to an evaluation of my professional competency, including any information relating to any disciplinary action, suspension, or curtailment of dental privileges, and also including such elements of my character, morals, and ethics which may reasonably be considered to have an impact upon my professional competency and reputation, by any hospital, professional society, licensing authority, health maintenance organization, dental plan organization, health insurer, malpractice insurer, attorney, data bank, or any other person or entity which may possess such information.
- (iii) I authorize United Concordia Companies, Inc. and their affiliates, subsidiaries, or related entities to consult with hospital administrators, the State board, malpractice carriers, and other persons to obtain and verify information. I release United Concordia Companies, Inc. and their employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluation of my application.
- (iv) I release from liability any and all individuals and organizations, including, but not limited to hospitals, medical staff offices, professional societies, licensing authorities, and health and dental maintenance organizations, who provide information to the credential verification organization, in good faith and without malice, information concerning my professional competence, ethics, character and other qualification for professional service.

TO BE COMPLETED BY DENTIST

Print Full Name

Date

Signature (Stamps NOT Accepted)

United Concordia Companies, Inc. will not deny an application for participation or terminate participation in its provider network on the basis of gender, race, religion, age, national origin or sexual orientation.

Once completed, you can submit using any of the following methods:

Website: <https://www.unitedconcordia.com/pifria>

Email: ProviderRequests@ucci.com

FAX: (844) 235-7261

Mail: Dental Network Operations

PO Box 69404

Harrisburg, PA 17106-9404