United Healthcare | Dental Benefit Providers®

Dental Benefit Providers, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers Services of New York IPA, Inc.; National Pacific Dental, Inc.; and Nevada Pacific Dental, Inc.

Provider Application (please complete for each dentist)

Practitioner Information

Note: **Dentist Name is required as it appears on dental license and this name should be used for claim submission.** Dentists applying for participation in the above network(s) under a participating practice's Dental Provider Agreement agree to be bound by those same terms and conditions of the Dental Provider Agreement and any associated protocols therein.

First Name:	MI:	Last Name:	☐ DDS ☐ DMD	☐ Male ☐ Female	☐ Associate ☐ Owner

Date Of Birth: / /	SSN:	NPI No. (Type 1/Individual):	Medicaid No. (Individual):	Medicaid No. (Site):	Name as it appears on Dental Degree:

Dentist Non-English Language(s)	Dentist E-mail Address:

Specialty: ☐ General Dentist ☐ Endodontist ☐ Oral Surgeon ☐ Orthodontist ☐ Pediatric Dentist ☐ Periodontist ☐ Prosthodontist

License and Registration Information (*Current copies must be sent with application.)

State: *Dental License No.:	*Drug Enforcement Agency (DEA) No.:	*Controlled Dangerous Substance (CDS) No., if applicable:

Additional Dental License Numbers (active or inactive)

State: Dental License No.:	State: Dental License No.:	State: Dental License No.:	State: Dental License No.:

Professional Liability Coverage (malpractice)

☐ Prof. Liability Ins. ☐ Fed. / State Tort Cov.	Carrier:	Per Claim Amt.:	Eff. Date: / /
	Policy / FTCA No.:	Aggregate Amt.:	Exp. Date: / /

Education and Training

Full Name of U.S. Dental School:	Graduation Mo/Yr:

Address:	City:	State:

Country of Dental School: ☐ United States ☐ Other, please list country:

For dental training outside the U.S., show the State requirements that have been met allowing you to practice in the U.S. and the accredited organization attended:

Specialty Training / Residency

Name of Institution:	Completion Mo/Yr:

Address:	City:	State:

Training: ☐ Endodontist ☐ Oral Surgeon ☐ Orthodontist ☐ Pediatric Dentist ☐ Periodontist ☐ Prosthodontist

Board Certified? ☐ Yes ☐ No	Certifying Board Name:	Last Certification Year:

5 Year Professional Work Experience (Beginning with current / must list month and year.)

Name of Practice	Location (City, State, Country)	Month/Year Started	Month/Year Ended

Work history gaps greater than 6 months must be explained:

All fields must be completed, if applicable.

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Provider Application (please complete for each dentist)	Practitioner Name:

Professional Questions and Attestation

	For each "YES" response, please provide a detailed/clinical explanation below. (An incorrect answer, or failure to provide an explanation, may delay the credentialing process.)	Yes	No
1.	Have there ever been actions against or investigations relating to your professional license(s) in any jurisdiction?	☐	☐
2.	Have there ever been any actions against or investigations relating to your hospital, DHMO and/or health/managed care plan privileges?	☐	☐
3.	Have you had any actions against or investigations relating to your DEA registration and/or CDS certification within the past five years?	☐	☐
4.	Have you ever voluntarily or involuntarily surrendered your license, DEA registration, CDS certificate, or hospital, DHMO or health/managed care privileges?	☐	☐
5.	Are there currently any restrictions on your license or limitations on your scope of practice?	☐	☐
6.	Have you been named in, or had a judgment or settlement in a malpractice action within the past five years?	☐	☐
7.	Have you been without professional liability insurance coverage in the past five consecutive years (Massachusetts: past ten consecutive years?) or has coverage ever been denied, suspended, modified, canceled, limited to exclude specific procedures, or not renewed by the action of any insurance company?	☐	☐
8.	Have you ever been convicted of a felony or named as a defendant in any past or pending criminal proceeding, excluding traffic violations? If yes, explain all occurrences and include arrest disposition.	☐	☐
9.	Have you ever been sanctioned or disciplined by a professional organization (to include a request to surrender membership)?	☐	☐
10.	Has there ever been any disciplinary action, suspension, probation, formal reprimand or request to resign during your education, internship, residency, fellowship, or other applicable training, including board certification?	☐	☐
11.	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?	☐	☐
12.	Is there anything that would prevent you from being able to competently perform essential job-related functions without risk to patient safety or health, with or without reasonable accommodation?	☐	☐
13.	Are you currently using illegal substances or are you dependent on alcohol, drugs, or illegal substances?	☐	☐

Affirmative answer explanation: If additional space is needed, please attach explanation on separate sheet.

Question #	

Question #	

All fields must be completed, if applicable.

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Provider Application (please complete for each dentist)	Practitioner Name:

Attestation/Consent and Release Form

I hereby give permission to Plan/Network, directly and/or through a third-party designee, to request information regarding my professional credentials and qualifications from educational facilities, the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, federal and state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.

The information requested may include otherwise privileged or confidential material relative to my qualifications, credentials, claims history, clinical competence, character, ethics, or any other matter applicable to the credentialing procedure. I release and agree to hold harmless the Plan/Network and its third-party designee, and their respective representatives from all liability for any damages or costs resulting from the gathering or good faith use of the information provided.

I hereby authorize the education facilities, hospital(s) in which I currently have or formerly have had privileges, professional certification boards, federal and state regulatory and licensing departments, malpractice insurance carriers, other professional monitoring entities, and present and past employers to submit information requested by Plan/Network, directly and/or through its third-party designee. If applicable, I authorize the Physician Recovery Network or applicable recovery program to release to Plan/Network information regarding my health status and participation status in any treatment program(s). I further release and agree to hold harmless all entities and their representatives referenced above from all liability related to the provision of information as long as such provision is done in good faith and without malice.

I agree that the photocopy/facsimile of this document with my signature may be accepted by any person or entity from which information is sought with the same authority as the original, and I waive written notice from any such entities or individuals who may provide information.

I understand that a condition of this application is that any misrepresentation or omission from this application, whether intentional or not, is a cause for rejection by Plan/Network and may result in termination if participation has been awarded to me. I agree to use my best efforts to inform Plan/Network in writing within 15 days if there is any change in the informationprovided or the answers to questions on the application as a result of developments subsequent to my signing this application.

I warrant that I have the authority to sign this application, on my behalf, and on behalf of any entity/practice for which I am signing as a representative.

If I am accepted for participation, I consent to the inspection of my patient records for Plan Members as necessary for peer and utilization review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual.

I understand that I have the right to review and correct erroneous information obtained by Plan/Network to evaluate my application, including information obtained from primary sources such as insurance carriers, licensing boards, or the National Practitioner Data Bank (NPDB). The review must take place within 6 months of application submittal. Corrections must be made in writing within 30 days of the review. This does not require Plan/Network to divulge references or other peer review protected information.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Plan/Network may report the rejection to the appropriate licensing board, NPDB and/or Health Care Integrity and Protection Data Bank.

I represent the information provided in or attached to this application is accurate and complete. I attest to having adequate current malpractice insurance for the state(s) in which I practice. I certify that I hold a full, unrestricted license to practice in the state in which I reside or I have indicated on this application the limitations and/or restrictions imposed.

This health care organization, and its third-party designee, does not discriminate on the basis of race, color, national origin, sex, relation, age or disability.

Your signature is required to complete this document. Stamped signatures are not acceptable.

Practitioner Name (Printed)	Practitioner Signature	Date (MM/DD/YYYY)

All fields must be completed, if applicable.

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Location Information			Practitioner Name:		
Practice Name:			Name of Owner(s):		
Primary Office Address:	Suite:		City:	State:	ZIP:
County	Office Phone No.: ( )		Office Fax No.: ( )	Tax ID (Submit W-9 form):	
Month/Year Start Date: /	Will a patient be able to routinely book an appointment with you at this location? ☐ Yes ☐ No				
Mailing Address (if different from primary):	Suite:		City:	State:	ZIP:
NPI No. (Type 2/Organization):	Group Medicaid ID:		For Medicaid only: Please indicate the NPI Number that was registered with the State as the Billing NPI number for this location:		
Office E-mail Address (Directory Publication):	Allow UnitedHealthcare to display Office E-mail Address in directories if intended for patient communication, regularly monitored and meets State/Federal health privacy laws. ☐ Yes ☐ No				
Office E-mail Address for UnitedHealthcare Correspondence:			Office Website:		

Facility Type (Check all that apply for this location):

☐ Private Practice	☐ Essential Community Provider (ECP)	☐ Portable Dental Operations (PDO)	☐ Dental School Based Practice
☐ Health Department (HD)	☐ Federally Qualified Health Center (FQHC)	☐ Mobile Dental Facility (MDF)	☐ Hospital Based Practice
☐ Urban Indian (UI)	☐ School Based Health Center (SBHC)	☐ Indian Services Provider (ISP)	☐ Community Health Center (CHC)

Is your office on or near a public transportation line? ☐ Yes ☐ No	Is your office handicap accessible? ☐ Yes ☐ No
Are you able to treat: Special needs patients? ☐ Yes ☐ No Wheelchair confined patients? ☐ Yes ☐ No	List Patient Age Limits: Minimum Age: _____ Maximum Age: _____

Office Staff Non-English Language(s):

Office Hours

Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:

Sedation/Anesthesia Information (applies to dentists only; not applicable to local anesthesia)

1. Are any forms of sedation and/or general anesthesia administered **by anyone** in your practice location? ☐ Yes ☐ No
   (Refer to CDT codes under Section 1, XII. Adjunctive General Services, Anesthesia. If yes, please continue to question 2. If no, do not complete 2 to 5)
2. Do you have healthcare clinicians (DDS, MD, CRNA), **other than yourself,** providing sedation and/or general anesthesia on patients you are treating at your practice location? ☐ Yes ☐ No
3. Do **you** administer any form of sedation and/or general anesthesia? ☐ Yes ☐ No
   (If yes, please continue to 4 and 5 and sign and date below. If no, do not complete 4 and 5, signature not required below.)
4. Please select the type(s) of sedation you (the applicant) administer and provide your applicable permit/license information below:

☐ Deep Sedation/General Anesthesia	Permit/License # _____	Exp. Date: / /	State: ___	☐ No state-issued permit/license
☐ Moderate/Conscious Sedation (all types)	Permit/License # _____	Exp. Date: / /	State: ___	☐ No state-issued permit/license
☐ Minimal Sedation (all types)	Permit/License # _____	Exp. Date: / /	State: ___	☐ No state-issued permit/license
☐ Pediatric Moderate/Conscious Sedation (all types)	Permit/License # _____	Exp. Date: / /	State: ___	☐ No state-issued permit/license
☐ Nitrous Oxide	Permit/License # _____	Exp. Date: / /	State: ___	☐ No state-issued permit/license
☐ Other Sedation Type: _____	Permit/License # _____	Exp. Date: / /	State: ___	☐ No state-issued permit/license

5. Please select if you are an Owner or Associate and sign and date below:
   - ☐ Owner: Please confirm that you comply with and have verified that each of those individuals providing patients with any form or level of sedation, anesthesia and/or nitrous oxide comply with all State requirements, including, but not limited to, those regarding equipment, supplies and training.
   - ☐ Associate: Please confirm that you comply with all State requirements in providing patients with any form or level of sedation, anesthesia and/or nitrous oxide, including, but not limited to, those regarding equipment, supplies and training.

Practitioner Signature: Date: / /

Please send completed applications along with current copies of all other required documents

Name: Nick Sosik E-mail: nicholas_sosik@uhc.com Phone: 952-406-3419
Address: Fax: 844-384-5882

NOTE: A Dental Provider Agreement is required, if not already on file for this practice.

All fields must be completed, if applicable.