INSTRUCTIONS FOR COMPLETION OF THE CONFIDENTIAL CREDENTIALING APPLICATION

The Confidential Credentialing Application must be completed by the contracted dentist. Your responses on this application will be used to determine whether you meet the eligibility criteria for participation in the network. As a treating dentist, you must maintain eligibility throughout the term of your participation. Responses must be legible. You may include any response which cannot be completed in the spaces provided on supplementary sheets of paper and attach them to your submittal. **Do not leave any fields blank**. If an item is not applicable, indicate N/A.

You must include the following with this completed application:
(Use this checklist as a guide)

- Application completed in its entirety for an initial credentialing or recredentialing submittal
- Copy of **all** current State license(s)
- Copy of **all** current DEA registrations (if applicable)
- Copy of current State Controlled Dangerous Substance (CDS) certificate (if applicable)
- Copy of the certificate of current Professional Liability Insurance policy face sheet, showing expiration dates, dollar amount of liability limits and dentist's name
- Proof of American Board Certification (if applicable)
- Copy of Curriculum Vitae/Resume (include last five (5) years of dental work history, or date of graduation from dental school)
- Copy of current state-issued driver's license or identification card
- Copy of diploma or specialty training certificate

CONFIDENTIAL CREDENTIALING APPLICATION

Dentist Information

Last name: _____ First name: _____

Type 1 NPI: _____ Date of birth: _____

Dentist email address: _____

Primary Specialty Type:

☐ General dentist ☐ Orthodontist ☐ Oral surgeon ☐ Prosthodontist
☐ Pediatric dentist ☐ Endodontist ☐ Periodontist

Primary Location

Practice name : _____ Start date (MM/YYYY): _____

Practice address: _____

City: _____ State: _____ ZIP: _____

Confidential credentialing contact name: _____

Credentialing contact email: _____

Direct number: _____ Fax number: _____

Dentist information continued

Last name: _____ First name: _____ Middle initial: _____

Other name(s) used: _____

Dentist Social Security number: _____ (Mandatory field needed for primary source verifications)

☐ DDS ☐ DMD ☐ Other Gender: ☐ Male ☐ Female ☐ Other ☐ Undisclosed

Dental school: _____ MM/YYYY graduated: _____

Specialty school (if applicable): _____ MM/YYYY graduated: _____

Are you "American Board Certified" in any of the below Specialties: if yes, please check the applicable board

☐ ABO-Orthodontist ☐ ABOMS-Oral Surgeon ☐ ABP-Prosthodontist
☐ ABPD-Pediatric Dentist ☐ ABE-Endodontist ☐ ABP-Periodontist

If you have hospital privileges check here ☐ If no, skip to the next question. If yes, list the hospital(s) for which you have privileges. _____

Licenses and Permits

Dental License#: _____ State: _____ Exp. date: _____

Additional Dental License(s) #:_____ State: _____ Exp. date: _____

DEA Certificate #: _____ Exp. date: _____

If you no longer have a DEA, please complete the below information. If not applicable, please skip to the next question.

Reason for not renewing DEA: _____

If a patient needs narcotics prescribed, they will be: ☐ Referred to another dentist/oral surgeon ☐ Referred to their primary care physician. If another dentist is prescribing, please confirm the prescribing dentist's name below:

Dentist's name: _____ DEA #, if known: _____

Controlled Substance Certificate #: _____ Exp. Date: _____

Do you have a current license or permit to administer conscious sedation/general anesthesia?
☐ Yes ☐ No ☐ N/A

Type: ☐ IV Sedation ☐ General Anesthesia Permit #: _____ Exp. Date: _____

Professional Liability

Effective date: _____ Liability type: ☐ Professional ☐ Tort ☐ Self-insured

Prof. Liability Ins. Co: _____ Policy #: _____

Liability limits: (Each claim): _____ (Aggregate claim): _____
Exp. date: _____

Past 5 Years Dental Work History	Start Date: MM/YYYY	End Date: MM/YYYY
1.		
2.		
3.		
4.		

Explanation of gaps of six months or more within the past 5 years:	Start Date: MM/YYYY	End Date: MM/YYYY

If you are a recent dental school graduate, please enter your state board dental license effective date here: _____

Professional Attestation and Questions		
I. Credentialing History (Please answer questions 1 - 10 below. For any "Yes" answer, explain on a separate sheet of paper.)		
Yes	**No**	**In the Past 10 Years:**
☐	☐	1. Has your license to practice in any jurisdiction, whether past or still pending, been denied, restricted, limited, suspended, revoked, not renewed, placed under probation, subjected to disciplinary or non-disciplinary action, or otherwise sanctioned, limited or curtailed?
☐	☐	2. Has your professional liability insurance ever been denied, suspended, revoked, canceled, or not renewed?
☐	☐	3. Has your Federal and/or State DEA license or applicable drug license ever been denied, suspended, canceled or not renewed, or subjected to any disciplinary action?
☐	☐	4. Has your status as a dentist ever been denied, suspended, canceled or sanctioned by any municipal, state, federal, or any other governmental agency (e.g. Medicare, Medicaid or Denti-Cal) HMO, EPO, PPO or other prepaid health plan including being listed on OIG, SAMs, or a State Exclusion List?
☐	☐	5. Are your privileges or memberships at any hospital, institution (military service) and/or HMO currently under investigation or have they ever been denied, suspended, reduced or not renewed?
☐	☐	6. Have you ever been denied membership, or renewal of membership, or been subject to disciplinary proceedings for a medical, dental or ethical reason by any dental/professional organization?
☐	☐	7. Are you unable to perform any procedures within the scope of privileges and duties in your position as a health care dentist, with or without reasonable accommodations required by the Americans With Disabilities Act, within accepted standards of professional performance and without posing a direct threat to patients?
☐	☐	8. Do you currently, or did you in the last five years, engage in the unlawful use of illegal drugs, including the improper use of prescription drugs?
☐	☐	9. Do you have any felony or misdemeanor charges pending against you or have you ever been convicted of a felony, or pleaded "nolo contendere" to a felony?
☐	☐	10. Have you been involved in ANY malpractice (or any other civil) claims/lawsuits, settlements or judgments within the last 10 years? If yes, please provide detailed information on a separate sheet of paper including docket number of the case, location of the court, names of the parties, plaintiff(s) and defendant(s), dates of the incident(s), description of the incident(s), your involvement, current disposition, and the amount of the settlement(s).

II. Compliance & Malpractice Insurance (Answer questions 11 & 12. For any "NO" answer, explain on a separate sheet of paper.)		
Yes	No	
☐	☐	11. Do you follow Center for Disease Control guidelines for Infection Control in Dental Health-Care Settings and observe all applicable laws and regulations related to the practice of dentistry including, but not limited to, those dealing with infection control and employee safety in the workplace?
☐	☐	12. Do you have current professional malpractice insurance coverage and agree to maintain continuous, uninterrupted coverage while either a contracted dental dentist or an associate of a contracted dental dentist? Please note that under the terms of participation that you further agree to notify the Credentialing Department immediately of any policy cancellation, lapse in coverage, reduction in coverage maximum(s) or claims made.

I authorize the Credentialing Department to consult with professional liability carriers, and other persons or entities to obtain information concerning my professional qualifications including competence, ethics and other qualifications. I, the undersigned, hereby certify that the information requested by the Plan and provided herein, is truthful, correct and complete in all respects. I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for denying participation or termination as a contracting dentist with the dental plan. The undersigned hereby agrees to notify the Plan immediately of any changes in the above information.

Upon request, dentists have the right to review the information in their credentialing file and to ask for correction of any error or omission believed to be significant. To be accepted, any such requests must be submitted in writing to the Provider Onboarding department within 365 days of the dentist's last submission of completed credentialing forms. Dentists have the right to submit a written appeal to refute the basis for any adverse action by the Plan based on credentialing eligibility criteria. The time period in which to submit a written appeal is subject to state requirements and the dentist agreement. If the adverse action decision is upheld upon appeal, dentists may request a hearing before a hearing panel.

I authorize receiving credential communications electronically.

Dentist Signature (no signature stamps):		Date: