P.O. Box 327
Seattle, WA 98111-0327

PREMERA | BLUE CROSS

DENTAL PROVIDER CREDENTIALING APPLICATION

This application is not a contract. The information provided in this application is used to determine whether a practitioner meets our credentialing standards.

Internal use only (Contract Name) _____ ☐ PAR ☐ EMP

1. All areas must contain a response. The application must be signed. The release(s) must be signed. Requested information must be attached. Incomplete information may result in application being returned and/or delayed.

Note: Some areas may not be applicable to all Dental Care Professionals.

1. PERSONAL INFORMATION—LICENSE, REGISTRATION AND CERTIFICATES

Last Name First Middle

Date of Birth Social Security # Gender M☐ F☐ Degree

Current copy of DEA required
Fed/State Drug Enforcement Administration (DEA) # Expiration Date

Medicare Provider # Medicaid Provider #

Email NPI #

List languages spoken fluently, other than English

List languages written fluently, other than English

LICENSES* State License # Effective Date Expiration Date

**current copy of all state licenses required*

Do you have ownership interest in any other dental, health or medical related organization, e.g., dental lab, radiology facility, mobile testing, surgery center, etc.? ☐Yes ☐No

If Yes, please list Organization's Tax ID Number

Please list Dental Association memberships and officerships or directorships, if any

2. OFFICE PRACTICE INFORMATION

A. Effective Date at Primary Practice location (mm/yy)

Name of Practice / Affiliation or Clinic Name

Department Name (if hospital based)

Primary Office Street Address

City State ZIP **NPI #**

Patient Appointment Telephone Number ( ) Fax Number ( )

Mailing Address (if different from above)

Billing Address (if different from above)

Office Manager Name Email

Administration Telephone Number ( ) Fax Number ( )

Name Affiliated with Tax ID Number Federal Tax ID Number

PRACTITIONER NAME

Modification to the wording or format of the Dental Provider Credentialing Application may invalidate the application.

2. OFFICE PRACTICE INFORMATION (continued)

B. Effective Date at Secondary Practice location (mm/yy)

Name of Secondary Practice / Affiliation or Clinic Name

Department Name (if hospital based)

Secondary Office Street Address

City State ZIP **NPI #**

Patient Appointment Telephone Number ( ) Fax Number ( )

Mailing Address (if different from above)

Billing Address (if different from above)

Office Manager / Administrator

Administration Telephone Number ( ) Fax Number ( )

Name Affiliated with Tax ID Number Federal Tax ID Number

LIST OTHER OFFICE LOCATIONS WITH ABOVE INFORMATION ON A SEPARATE SHEET.

C. Please advise on the following services/information

☐ Second Surgical Opinion ☐ Accepting New Patients ☐ Lower Age Limits _____

☐ Workers' Comp. Services ☐ 24-hour Coverage ☐ Upper Age Limits _____

D. Normal Office Hours

Weekday hours (Monday-Friday) Weekend hours (Saturday-Sunday)

Provider works ☐ Full Time ☐ Part Time

E. Please identify any practitioners who provide coverage for your patients when you are unavailable.

Name Phone ( )

Address

City State ZIP

Primary Specialty Subspecialities

3. SPECIALTY, EDUCATION AND TRAINING

A. Please list your Primary Specialty

Second Specialty Third Specialty

Board Eligible in Date

Board Certified in Date

Recertified in Date

B. Dental/Professional School Name

Institution Address

Attended from (Month/Year) Until (Month/Year) Degree

Attended school under a different name? ☐ No ☐ Yes, Name _____

3. SPECIALTY, EDUCATION AND TRAINING (continued)

C. Foreign Graduates

Are you a foreign dental school graduate? ☐ Yes ☐ No

Are you certified by the Education Council for Foreign Dental Graduates? ☐ Yes ☐ No

IF YES TO EITHER, YOU MUST PROVIDE A COPY OF YOUR CERTIFICATE.

D. Internship/Specialty School (Post-Doctoral Training), if applicable

Institution Name

Mailing Address

Attended From (Month/Year) To (Month/Year) Type of Internship

Did you complete this program? ☐ Yes ☐ No

E. Residency One, if applicable

Institution Name

Mailing Address

Attended From (Month/Year) To (Month/Year)

Did you complete this program? ☐ Yes ☐ No

Specialty

F. ☐ Residency Two or ☐ Fellowship, if applicable

Institution Name

Mailing Address

Attended From (Month/Year) To (Month/Year)

Did you complete this program? ☐ Yes ☐ No

Specialty

G. Identify any specialty or subspecialty in which you are Board Certified without post-graduate training

4. HOSPITAL PRIVILEGES

☐ Check here if not applicable

Please list all hospitals where you CURRENTLY have active or admitting privileges. Please indicate privilege status:
1 - Active/Admitting; **2** - Associate; **3** - Courtesy; **4** - Provisional; **5** - Other (specify); **6** - No Privileges

Hospital Name City

Privilege Status Active Since

Hospital Name City

Privilege Status Active Since

Hospital Name City

Privilege Status Active Since

Use additional pages if necessary.

5. PROFESSIONAL MALPRACTICE LIABILITY INFORMATION

A. Current Insurance Carrier | Policy Number

Mailing Address

City | State | ZIP

Per claim amount $ | Aggregate amount $ | Date Began | Expiration Date

6. WORK HISTORY (Do Not Abbreviate)

Chronologically list all work history activities for the most recent 5 years (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient. Please explain any gaps on a separate page.

Name of Current Practice / Employer

Contact Name | Telephone Number ( ) | Fax Number ( )

Mailing Address

City | State | ZIP

From (mm/dd/yyyy) | To (mm/dd/yyyy)

Name of Practice / Employer

Contact Name | Telephone Number ( ) | Fax Number ( )

Mailing Address

City | State | ZIP

From (mm/dd/yyyy) | To (mm/dd/yyyy)

Name of Practice / Employer

Contact Name | Telephone Number ( ) | Fax Number ( )

Mailing Address

City | State | ZIP

From (mm/dd/yyyy) | To (mm/dd/yyyy)

Please account for all periods of time between date of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable.

From (mm/dd/yyyy) | To (mm/dd/yyyy)

From (mm/dd/yyyy) | To (mm/dd/yyyy)

From (mm/dd/yyyy) | To (mm/dd/yyyy)

From (mm/dd/yyyy) | To (mm/dd/yyyy)

7. PROFESSIONAL INFORMATION

Please answer the following questions with Yes or No. (If YES to any of these questions, please attach a detailed explanation that includes the outcome.)

1. Has your license to practice in this state or any other state been denied, restricted, limited, suspended or revoked; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license? ☐ Yes ☐ No
2. Has your DEA Registration ever been restricted, limited, suspended or revoked, or are any of these actions pending with respect to your DEA Registration? ☐ Yes ☐ No
3. Have your hospital privileges, if any, ever been revoked, suspended, reduced, or not renewed; have disciplinary proceedings ever been instituted against you; or are any of these actions now pending with respect to your hospital privileges? ☐ Yes ☐ No
4. Have you ever voluntarily relinquished hospital privileges, DEA Registration, academic appointments or any other professional status while an investigation was conducted? ☐ Yes ☐ No
5. Has your participation in Medicare, Medicaid or any other government program ever been denied, suspended or revoked; or, to the best of your knowledge, are you under investigation by a regulatory agency? ☐ Yes ☐ No
6. Have any complaints been filed against you with a dental/professional society? ☐ Yes ☐ No
7. Have any professional liability judgments been entered against you, including arbitration awards or are there professional liability suits currently pending against you? ☐ Yes ☐ No
8. Have any professional claim settlements, not involving litigation or arbitration, been paid by you or paid on your behalf? ☐ Yes ☐ No
9. Has your professional liability insurance ever been canceled or has professional liability insurance ever been denied? ☐ Yes ☐ No
10. Have you ever been convicted of a felony or do you have any felony or misdemeanor charges pending (other than minor traffic offenses)? ☐ Yes ☐ No

8. HEALTH STATUS

1. Are there any reasons physical or mental why you are not able to perform the essential functions of your position, with or without accommodation? ☐ Yes ☐ No
2. Do you now have or have you had a chemical dependency/substance abuse problem? ☐ Yes ☐ No
3. Are you currently taking any medications that may affect either your clinical judgment or motor skills? ☐ Yes ☐ No

If YES to any of the above questions, please attach a detailed explanation that includes the outcome.

9. PROFESSIONAL LIABILITY HISTORY

Please list any/all professional liability suits which are pending or which went to final disposition and resulted in payment to the plaintiff. Use additional sheets as necessary.

Patient Name

List Other Defendants

Incident Date Settlement/Judgment Date Amount

Professional Liability Insurer Involved # of Defendants

Alleged Harm to Patient

Describe Your Role in the Incident ☐ Primary Defendant ☐ Co-Defendant

Describe What You Were Alleged to Have Done Incorrectly

PRACTITIONER RELEASE AUTHORIZATION/CERTIFICATION

PO Box 327
Seattle, WA 98111-0327

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Note: This Release Authorization pertains only to professional information and is not intended as an authorization for release of protected health information.

In conjunction with my application to Premera Blue Cross (PBC), I hereby:

1. Authorize PBC to consult with members of medical or dental staffs, professional liability carriers, and other persons or entities concerning my professional dental qualifications.
2. Consent to the release, by any person or entity to PBC all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions, quality assurance data relating to me, or other related confidential or privileged information.
3. Agree that I shall notify PBC promptly of any material changes affecting my professional status.
4. Release PBC and their employees from liability for obtaining information and evaluating my application; I further release from any liability any other persons or entities providing information as authorized hereunder if acting in good faith and without malice.

It is understood that this Authorization Release is confined strictly to those matters mentioned and that PBC will treat all information obtained by them in a confidential manner and will not release such information to others without my prior consent.
I agree that a photocopy/facsimile (fax) of this document will serve the same purpose as the original.
I understand and agree that discovery of false or intentionally omitted material in this application may result in rejection of my application or termination of any contract awarded to me in consideration of this application.
I understand this submitted application will be considered in evaluating participation or continued participation in all provider networks sponsored by PBC and their subsidiaries and affiliates.
I understand that my office medical records will be subject to inspection by representatives of PBC.
I understand that completion and submission of this application does not automatically grant me a contracted status in any PBC provider network, but that such status is dependent, in part, on evaluation and approval of this application.
This application is not a contract.
I understand that until I am notified that this application is approved, and a written contract is in effect with PBC, I may not represent myself as a contracted provider in any PBC provider network. However, if I am already a contracted practitioner with PBC, I may continue in that status while evaluation of this application is pending with PBC.

Certification for the 1099 issued by Premera Blue Cross:

The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me). I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest of dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
I certify that the information contained in this application is complete, accurate and true.

Print Name _____ Signature _____ Date _____

REMINDER:
Sign and return all copies of the practitioner contracts (if applicable)
Are all 6 pages completed and required attachments included? Required attachments are:

- **Copy of all current state licenses**
- **Copy of current DEA certificate**
- **Copy of facesheet (declaration page) from current malpractice insurance coverage (if group policy, attach an addendum showing individual covered practitioner names)**
- **Any explanations as required**