

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 # _____
UPIN (Medicare Unique Provider ID Number) _____ 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 / Administrator _____
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 _____ Weekend hours _____
(Monday-Friday) (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 _____ Subspecialties _____

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 ()
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Mailing Address

City	State	ZIP
From (mm/dd/yyyy)	To (mm/dd/yyyy)	

Name of Practice / Employer

Contact Name	Telephone Number ()	Fax Number ()
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Mailing Address

City	State	ZIP
From (mm/dd/yyyy)	To (mm/dd/yyyy)	

Name of Practice / Employer

Contact Name	Telephone Number ()	Fax Number ()
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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



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