CREDENTIALING APPLICATION

This Credentialing Application cannot be processed until it is completed in FULL
Please maintain a copy of this Credentialing Application for your records

Information provided in this application must be consistent with information submitted on your claims

Credentialing Application is complete when:

☐ **The Credentialing Application has been updated in its entirety, signed and dated** (NO STAMPED SIGNATURES)

☐ **Current Copies** of the following have been **attached:**

- ✓ **Dental License** (provide copies for EVERY state in which you are licensed)
- ✓ **Federal** DEA Registration for **EVERY STATE** the DDS is participating in.
- ✓ **American** Board/Specialty Certificate (if applicable)
- ✓ **Controlled Dangerous Substance** (CDS) certificate for **EVERY STATE** the DDS is participating in.
- ✓ **Professional Liability Insurance Declaration** Page – showing minimum coverage of $1 million/$3 million, dentist's name, policy #, effective and expiration dates.
  - o **If expiration date** is within weeks of this application, updated documentation must be submitted.

☐ **W-9 Form or Employer Identification Number Letter (EIN)**

☐ **Facility Profile**

☐ **Automated Clearinghouse Authorization Agreement**

If you are a dentist seeking credentialing for a new office location, call Customer Service at 1-800-433-6335. You will be given the contact information for your Network Representative to obtain a Participating Location Group Dental Agreement. This agreement is required to participate in our network.

MAIL CREDENTIALING APPLICATION TO:

Horizon Professional Services
Attn: Credentialing
PO Box 153
Minneapolis, MN 55440-9886

or email to: Horizoncredentialing@decare.com

You also have the option of faxing this information to us at: 1-855-311-1373
Questions? Call (toll free) 1-855-648-1408

Notice of Applicant's Right

You may review or request the status of your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable State laws. If there are discrepancies in the information received during the credentialing process, you will be notified and allowed an opportunity to correct erroneous information submitted by another party within thirty (30) days of submitting your application. This includes information submitted by an outside primary source, such as Professional Insurance Carrier, State License Board and/or the National Practitioner Data Bank.

Confidentiality Statement

Information gathered as part of the credentialing or re-credentialing process is maintained in a confidential manner and will not be communicated or reproduced. This provision is designed to safeguard information and ensure confidentiality.

An Independent Licensee of the Blue Cross and Blue Shield Association

DEMOGRAPHICS (Please type or print) **STATE DENTAL LICENSE #:** ________________________

Name:	____________________ Last First MI
Social Security Number:	____ ____ ____ - ____ ____ - ____ ____ ____ ____
Select One:	☐ Owner ☐ Partner ☐ Associate
State Medicare Number:	____________________ Medicaid Number: ____________________
UPIN Number:	____________________
Children's Health Insurance Plan (CHIP) #:	____________________
(Individual) NPI Number:	____ ____ ____ ____ ____ ____ ____ ____ ____ ____
Date of Birth:	____ ____ / ____ ____ / ____ ____ ____ ____
Gender:	☐ Male ☐ Female
Do you currently hold a Federal DEA registration?	☐ YES (Submit copy) ☐ NO
Languages Spoken Fluently	

GENERAL DENTISTRY EDUCATION

Institution	Grad Date	Degree

SPECIALTY EDUCATION

Institution	Grad Date	Degree

For the above **SPECIALTY**, I am:

☐ Educationally Qualified (showing institution **name, grad yr, and specialty**)

☐ **AMERICAN Board Certified *** (attach certificate copy from **American Board**)

* Date of Certification: ____________________ Expiration Date: ____________________

PROFESSIONAL LIABILITY INSURANCE FOR EACH ENTITY IN WHICH YOU PRACTICE AT
(Complete information below OR attach copy)

CARRIER:	**POLICY #:**
COVERAGE LIMITS (Occurrence/Aggregate):	
EFFECTIVE DATE:	**EXPIRATION DATE:**

The selection process ensures that Credentialing decisions are not based on an applicant's race, ethnicity/nationality, gender, age, sexual orientation, or the types of patients or procedures in which the dentist specializes.

DDS NAME AND STATE DENTAL LICENSE NUMBER (As indicated on your license copy):

____

PRIMARY PRACTICE LOCATION **If more than one location please attach a separate sheet with the below information.**

Group/Practice Name:	______________________________
Street Address (Building; Street; Suite #):	______________________________
City/State/Zip:	______________________ County: __________
Office Phone Number:	(______) ______________ ER/After Hours Number: (______) ______________
Fax Number:	(______) ______________ Office Email: ______________________
Tax ID Number (TIN): AS LISTED ON W-9	_____ _____ - _____ _____ _____ _____ _____ _____ _____
(Location) NPI Number:	Clinic: __ __ __ __ __ __ __ __ __ __ Corporate: __ __ __ __ __ __ __ __ __ __
Office Manager/Contact:	______________________________
	Are office protocols for infection control in compliance with current CDC/OSHA guidelines? ☐Yes ☐ No

CORRESPONDENCE INFORMATION: (If different from primary practice location) This address is used to send communications such as welcome letters and newsletters		**BILLING INFORMATION:** (if different from primary practice location) This address is for claim reimbursement	
Address:	______________________	Address:	______________________
	______________________		______________________
Office Manager/Contact	______________________	Office Manager/Contact	______________________

EMPLOYMENT HISTORY: Chronological listing must include **MONTH and YEAR** for each entry of employment history for the **MOST RECENT 5 years.** List all armed service, public health, education, business or professional activities, sabbatical, etc. LEAVE **NO GAPS** IN CHRONOLOGY

Dates (Month & Year)	Facility and Address	Phone Number & TIN	Reason for Leaving:
From: ____ / ____ To: **Present**	Current Location		
From: ____ / ____ To: ____ / ____			
From: ____ / ____ To: ____ / ____			

PRIMARY ADMITTING FACILITY (List present hospital/surgical center privileges in chronological order beginning with the most recent.)

Primary Admitting Facility:	______________________________
Type of Status:	______________________________
Street Address:	______________________________
City/State/Zip:	______________________________
Dates (Month/Year):	From: To:

DISCLOSURE QUESTIONS

Please complete the Professional Liability Addendum if questions 1-10 are answered in the affirmative.

1. ☐Yes ☐No **Have you ever** had your **professional license, registration or DEA** terminated, stipulated, restricted, limited, conditioned, subjected to corrective action, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?
2. ☐Yes ☐No **Have you ever** had your **membership, participation, clinical privileges, or employment** denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?
3. ☐Yes ☐No **Have you ever** voluntarily/involuntarily relinquished your **membership, participation, clinical privileges or request for privileges, employment, professional license, or registration** as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?
4. ☐Yes ☐No **Have you ever** been reprimanded, censored, or otherwise disciplined by, or have you been subject to a corrective action agreement/plan with any **licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**
5. ☐Yes ☐No **Have you ever** had your certificate or participation in **any private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?
6. ☐Yes ☐No Are there any **charges pending or have you ever** been indicted, found guilty of a felony, misdemeanor (other than minor violations), or other offenses involving fraud, misrepresentation, dishonesty or deceit? Are you currently using illegal drugs?
7. ☐Yes ☐No **Have you ever** been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment?
8. ☐Yes ☐No **Have you ever** had any Malpractice (Professional Liability) claims or lawsuits brought against you, including pending, dismissed or dropped claims/lawsuits, settlements or final judgments? (This includes status of any pending claims previously reported.)
9. ☐Yes ☐No **Have you ever** had your Malpractice (Professional Liability) carrier refuse or cancel your coverage?
10. ☐Yes ☐No Do you have a condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing a significant health or safety risk to your patients?
11. ☐Yes ☐No Is your Professional Liability current with limits $1 million/$3million?

DISCLOSURE QUESTIONS & DENTIST CONSENT

I hereby certify that to my knowledge that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary while my application is being processed. I agree to notify any changes in malpractice coverage, including changes in the insurance carrier or policy number, as they occur.

By completing this application to become a participating dentist, I fully understand that any significant misstatement in, or omission from, my application to become a participating dentist may constitute cause for denial of my application or the subsequent termination of my participating dentist contract if my application is accepted. I understand and agree that this consent is irrevocable for any period during which I am a participating dentist. Reserved is the right to base acceptance into any individual network based on criteria established.

I understand that my application may require review of information related to me on file with other entities, including but not limited to, state licensing boards, specialty boards, professional societies, malpractice carriers, and the National Practitioner Data Bank administered by the U.S. Government.

I authorize release from liability all representatives, including any agent, my state licensing board, clinics, other institutions, professional societies, professional malpractice insurance carrier(s) and any staff, for their acts performed in good faith and without malice in connection with the gathering and exchange of information as consented above or to release information as required by State or Federal laws, rules, or regulations.

I understand and agree that I have the responsibility of producing adequate information for proper evaluation of my continued professional competence, ethics and other qualifications and for resolving any doubts about such qualifications. I further understand and agree that I have a continuing affirmative duty to immediately inform of any future restrictions or revocation of my professional license, any disciplinary action, suspension or voluntary/involuntary limitation, denial of my clinical or other privileges, or any other event which may adversely reflect upon my professional competence, ethics and other qualifications as a participating dentist.

I understand that subject to proper confidentiality restrictions and authorizations, my dental records will be subject to inspection for quality assurance and utilization review purposes.

Signature ______________________________ **Date** ________________

Name ______________________________ **Dental Lic #:** ________________

(Please print or type)

PROFESSIONAL LIABILITY ADDENDUM

Complete addendum if you answered "YES" to Disclosure Questions 1-10.
Attach separate sheet if necessary.

Malpractice Claim(s)

Date of Occurrence: ______________________ Settlement Amount: ______________________

Name & Address of Insurance Carrier: ______________________

Current Status of Claim: ______________________ Date Claim Resolved: ______________________

Details of Allegations: ______________________

Board Action(s): Attach copy of Board Action/Corrective Action

Date of Occurrence: ______________________ Date of Satisfaction/Closure: ______________________

Amount of Fine Paid: ______________________

Details of Action (conditions, limitations etc.):