DELTA DENTAL®

CONFIDENTIAL CREDENTIALING INFORMATION FORM

This form must be completed by the contracting dentist. Your responses on this form will be used to determine whether you meet the eligibility criteria for participation in the network. Treating dentists must maintain eligibility throughout the term of their participation.

1. Provider Information

Last Name: _____ First Name: _____ Middle Initial: _____

Other name used: _____

❑ DDS ❑ DMD ❑ Other _____ ❑ Individual NPI Number: _____

Date of Birth: _____ (DOB is mandatory) ❑ Male ❑ Female ❑ Dentist Social Security # _____ (SS# is mandatory here not Tax ID or NPI)

Dental School: _____ Month/Year Graduated: _____

Specialty School (if applicable): _____ Month/Year Graduated: _____

❑ General Dentist ❑ Orthodontist ❑ Oral Surgeon ❑ Prosthodontist

❑ Pedodontist ❑ Endodontist ❑ Periodontist

Are you currently American Board Certified? ❑ Yes ❑ No If yes, indicate which Specialty Board: _____

List hospital for which you have privileges: (List any additional hospitals on back.)

Name: _____ Address: _____

Copies of the following documents are required - Copies must be clear, legible and current.

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

Additional Dental License #: _____ State: _____ Exp. Date: _____

DEA Certificate #: _____ DEA 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: _____

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

Liability Limits: *(Each Claim)* _____ *(Aggregate Claim)* _____ Policy Exp. Date: _____

Practice Name: _____ **Start Date**: Month/Year _____

Practice Address: _____

City: _____ State: _____ Zip: _____

Business NPI Number: _____ TIN #: _____

Office Contact Person: _____ Office Email: _____

Office Phone: _____ Office Fax Number: _____

If applicable:

Controlled Substance Certificate #: _____ Exp. Date: _____

Please provide your state issued Medicaid number: _____

2. Dental Work History for the Past Five Years

Dentist Name	Dentist License Number	State Issuing License

You must list a complete work history for the past five years including dates. Please provide an explanation of any work gaps greater than six months during the past five (5) years. If you have fewer than five (5) years of work history, please include your initial licensing date.

	Practice/Group Name	Month/Year	Month/Year
1.	_____	**Start Date:** _____	**End Date:** _____
2.	_____	**Start Date:** _____	**End Date:** _____
3.	_____	**Start Date:** _____	**End Date:** _____

Explanation of gaps of six months or more:

	Time Period **Start Date:**	**End Date:**
_____	_____	
_____	_____	

3. Provider Checklist

Please note, we must receive the following documents from you in order to process your application:

- ❑ A complete copy of this form (*"Credentialing Information Form"*)
- ❑ A copy of each dentist's DEA certificate (if applicable) with a future expiration date
- ❑ A copy of the declaration page /certificate of coverage of each dentist's malpractice insurance with a future expiration date

Date Stamp

Return this form to:
Delta Dental of Tennessee
Professional Relations Dept. 240
Venture Circle
Nashville TN 37228
Fax: 615-742-6940
Email: cbruce@deltadentaltn.com

TO EXPEDITE THE CREDENTIALING PROCESS, THIS PAGE MUST BE COMPLETED IN ITS ENTIRETY.

4. Professional Attestation and Questions

Dentist First Name (Please print)	Middle Initial	Last Name

Dentist Date of Birth	Dentist License Number	State Issuing License

I. Credentialing History (Please answer questions 1 - 10 below. For any "Yes" answer, explain on a separate piece of paper.)

Yes	No		
❑	❑	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 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 provider ever been denied, suspended, canceled or sanctioned by any municipal, state, federal or any other governmental agency (e.g. Medicare, Medicaid, OIG or Denti-Cal) HMO, EPO, PPO or other prepaid health plan?
❑	❑	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 provider, 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 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 **five 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 and 13. 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 work place?
❑	❑	12.	Do you have current professional malpractice insurance coverage and agree to maintain continuous, uninterrupted coverage while either a contracted dental provider for the Plan or an associate of a contracted dental provider? Please note that under the terms of participation that you further agree to notify the Plan immediately of any policy cancellation, lapse in coverage, reduction in coverage maximum(s) or claims made.
❑	❑	13.	Is practice accepting new patients?

I authorize the Plan 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, practitioners 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 Administration department within 365 days of the practitioner's last submission of completed credentialing forms. Practitioners 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 provider agreement. If the adverse action decision is upheld upon appeal, practitioners may request a hearing before a hearing panel.

Dentist Signature (no signature stamps): _____ Date: _____