MARYLAND INSURANCE ADMINISTRATION

Maryland Uniform Dental Credentialing Form

Instructions

Read all instructions carefully prior to submitting your application.

This form may be completed and sent electronically or in printed form.
Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another application or credentialing form.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Enter information legibly and inside the boxes and spaces provided.
4. Complete all sections that are applicable to you. Use supplemental forms where appropriate.
5. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 24-26.
6. Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 — Personal Information and Professional IDs

Provider Type

Code list is found on page 24. Enter the associated 3-digit code in the space provided.*

☐ YES ☐ NO DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?*

Name

Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME* | SUFFIX (JR, III)

FIRST NAME* | MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?* ☐ YES ☐ NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME | SUFFIX (JR, III)

OTHER FIRST NAME | OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (MM/DD/YYYY) | DATE STOPPED USING OTHER NAME (MM/DD/YYYY)

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 25-27. Enter the associated 3-digit code in the space provided.

GENDER* ☐ MALE ☐ FEMALE | DATE OF BIRTH* (MM/DD/YYYY)

CITY OF BIRTH | STATE OF BIRTH | COUNTRY OF BIRTH

SSN* | FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) | FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Home Address

NUMBER | STREET | APT NUMBER

CITY | STATE | ZIP CODE

TELEPHONE

NOTE: This information used for application follow-up.

E-MAIL

FAX | PREFERRED METHOD OF CONTACT* ☐ E-MAIL ☐ FAX

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 — Personal Information and Professional IDs (Continued)

Professional IDs

Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

Non-licensed professionals should enter certification/ registration number in the space provided for license number.

FEDERAL DEA NUMBER

DEA ISSUE DATE (MM/DD/YYYY)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (MM/DD/YYYY)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (MM/DD/YYYY)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (MM/DD/YYYY)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (MM/DD/YYYY)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE (MM/DD/YYYY)

PROVIDER TYPE CODE — Provider Type Code List is found on Page 24.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (MM/DD/YYYY)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE (MM/DD/YYYY)

PROVIDER TYPE CODE — Provider Type Code List is found on Page 24.

Other ID Numbers

Indicate all that apply.

ARE YOU A PARTICIPATING MEDICAID PROVIDER?* ☐ YES ☐ NO

MEDICAID NUMBER

MEDICAID STATE

NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER

USMLE NUMBER (WITHOUT HYPHENS)

WORKERS COMPENSATION NUMBER

0 —

ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)

ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) (MM/DD/YYYY)

License Status

Indicate all that apply.

GENERAL DENTAL LICENSE ☐ YES ☐ NO

LIMITED DENTAL LICENSE ☐ YES ☐ NO

TEMPORARY DENTAL LICENSE ☐ YES ☐ NO

INACTIVE DENTAL LICENSE ☐ YES ☐ NO

TEACHER'S DENTAL LICENSE ☐ YES ☐ NO

OTHER LICENSE STATUS — Status Code List is found on Page 24.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 — Education and Training

Undergraduate School

Provide the appropriate information for the school that issued your undergraduate degree.

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY | STATE | ZIP/POSTAL CODE

COUNTRY CODE | TELEPHONE | FAX

START DATE (MM/YYYY) | END DATE (GRADUATION DATE) (MM/YYYY) | DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO | DEGREE AWARDED

Professional School(s)

Provide the appropriate information for the school that issued your professional degree.

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

GRADUATE TYPE*:

☐ U.S. OR CANADIAN GRADUATE ☐ NON-U.S./CANADIAN GRADUATE ☐ FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./ CANADIAN ONLY) | NAME OF U.S./ CANADIAN SCHOOL:

START DATE* (MM/YYYY) | END DATE (GRADUATION DATE)* (MM/YYYY) | DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO | DEGREE AWARDED

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY | COUNTRY CODE | POSTAL CODE

START DATE* (MM/YYYY) | END DATE (GRADUATION DATE)* (MM/YYYY) | DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO | DEGREE AWARDED

OTHER PROFESSIONAL SCHOOL

OFFICIAL NAME OF OTHER PROFESSIONAL SCHOOL

CITY | COUNTRY CODE

START DATE* (MM/YYYY) | END DATE (GRADUATION DATE)* (MM/YYYY) | DEGREE AWARDED

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 — Education and Training (Continued)

Training

List all training programs you attended. Use one section per institution.

Professional School Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

COUNTRY CODE | TELEPHONE | FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? ☐ YES ☐ NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

☐ INTERNSHIP/ RESIDENCY ☐ FELLOWSHIP ☐ OTHER

START DATE (MM/YYYY)) | END DATE (MM/YYYY)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

☐ INTERNSHIP/ RESIDENCY ☐ FELLOWSHIP ☐ OTHER

START DATE (MM/YYYY) | END DATE (MM/YYYY)

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

☐ INTERNSHIP/ RESIDENCY ☐ FELLOWSHIP ☐ OTHER

START DATE (MM/YYYY)) | END DATE (MM/YYYY))

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 — Professional / Dental Specialty Information

Specialty Status

GENERAL DENTIST ☐ YES ☐ NO

SPECIALIST ☐ YES ☐ NO PRIMARY SPECIALTY

Primary Specialty

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE

INITIAL CERTIFICATION DATE (MM/DD/YYYY)

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO ☐ YES ☐ NO PPO ☐ YES ☐ NO POS ☐ YES ☐ NO

BOARD CERTIFIED? ☐ YES ☐ NO

RECERTIFICATION DATE (IF APPLICABLE) (MM/DD/YYYY)

CERTIFYING BOARD CODE

EXPIRATION DATE (IF APPLICABLE) (MM/DD/YYYY)

IF NOT BOARD CERTIFIED (SELECT ONE) ☐ I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

☐ I INTEND TO SIT FOR AN EXAM ON (MM/DD/YYYY)

☐ I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Secondary Specialty

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE

INITIAL CERTIFICATION DATE (MM/DD/YYYY)

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO ☐ YES ☐ NO PPO ☐ YES ☐ NO POS ☐ YES ☐ NO

BOARD CERTIFIED? ☐ YES ☐ NO

RECERTIFICATION DATE (IF APPLICABLE) (MM/DD/YYYY)

CERTIFYING BOARD CODE

EXPIRATION DATE (IF APPLICABLE) (MM/DD/YYYY)

IF NOT BOARD CERTIFIED (SELECT ONE) ☐ I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

☐ I INTEND TO SIT FOR AN EXAM ON (MM/DD/YYYY)

☐ I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Primary Credentialing Contact

CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION ON PAGE 7 AS THE CREDENTIALING INFORMATION. ☐

LAST NAME

FIRST NAME

M.I.

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP CODE

TELEPHONE

FAX

E-MAIL ADDRESS (Even if you checked the boxes above, please provide the e-mail address, if available.)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE PRIMARY CREDENTIALING CONTACT QUESTION ON PAGE 5. SECTION 4 MAY BE LEFT BLANK AND YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 19-20.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

PREVIOUS OR FUTURE START DATE? (MM/DD/YYYY)

DENTAL GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* ☐ YES ☐ NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* ☐ USE INDIVIDUAL TAX ID ☐ USE GROUP TAX ID

Office Manager or Business Office Staff Contact

List office staff and billing contacts separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* ☐ YES ☐ NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION ☐

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Payee Contact.

TELEPHONE* FAX

E-MAIL ADDRESS

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

24/7 PHONE COVERAGE?* ☐ YES ☐ NO

IF YES ☐ ANSWERING SERVICE ☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE ☐ VOICE MAIL WITH OTHER INSTRUCTIONS ☐ COVERING COLLEAGUE ☐ OTHER

CURRENT WAIT TIME FOR INITIAL APPOINTMENT

NUMBER OF OPERATORIES AVAILABLE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* ☐ YES ☐ NO

ACCEPT ALL NEW PATIENTS?* ☐ YES ☐ NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* ☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?* ☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PROVIDER REFERRAL?* ☐ YES ☐ NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?*

☐ YES ☐ NO IF YES, EXPLAIN

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Mid-Level Practitioners

Identify the primary mid-level practitioners of your practice.

DO MID-LEVEL PRACTITIONERS CARE FOR PATIENTS IN YOUR PRACTICE?* ☐ YES ☐ NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., ADHA, RDH, CDA, RDA, CDT)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., ADHA, RDH, CDA, RDA, CDT)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE (E.G., ADHA, RDH, CDA, RDA, CDT)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information (Continued)

Languages

Code lists are found on pages 24-25. Enter the associated 3-digit code in the space provided.

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* ☐ YES ☐ NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* ☐ YES ☐ NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* ☐ YES ☐ NO
- PARKING?* ☐ YES ☐ NO
- RESTROOM?* ☐ YES ☐ NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* ☐ YES ☐ NO

- TEXT TELEPHONY (TTY)* ☐ YES ☐ NO
- AMERICAN SIGN LANGUAGE* ☐ YES ☐ NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* ☐ YES ☐ NO
- TDDY/HEARING IMPAIRED ☐ YES ☐ NO

ACCESSIBLE BY PUBLIC TRANSPORTATION?* ☐ YES ☐ NO

OTHER TRANSPORTATION ACCESS

Certifications

DO YOU HOLD THE FOLLOWING CERTIFICATIONS? IF YES, PROVIDE EXPIRATION DATES.

BASIC LIFE SUPPORT ☐ YES ☐ NO — EXPIRATION DATE (MM/DD/YYYY)

CPR ☐ YES ☐ NO — EXPIRATION DATE (MM/DD/YYYY)

Services

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES?

RADIOLOGY SERVICES? ☐ YES ☐ NO — IF YES, TYPES OF X-RAY EQUIPMENT — INTRAORAL X-RAY UNIT ☐ YES ☐ NO — PANOGRAPHIC X-RAY UNIT ☐ YES ☐ NO

ANESTHESIA SERVICES? ☐ YES ☐ NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE? — CONSCIOUS SEDATION? ☐ YES ☐ NO — NITROUS OXIDE? ☐ YES ☐ NO

IF YES, WHO ADMINISTERS IT?

LAST NAME | FIRST NAME

STERILIZATION METHODS USED — AUTOCLAVE ☐ YES ☐ NO — CHEMCLAVE ☐ YES ☐ NO

OTHER ☐ YES ☐ NO — EXPLAIN

TYPE OF PRACTICE (SELECT ONE ONLY)* ☐ SOLO PRACTICE ☐ SINGLE SPECIALTY GROUP ☐ MULTI-SPECIALTY GROUP

☐ CORPORATION ☐ LLC ☐ OTHER — EXPLAIN

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information (Continued)

Partners/ Associates

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 24)

STATE LICENSE NUMBER | LICENSE ISSUING STATE | LICENSE ISSUE DATE (DD/MM/YYYY)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 24)

STATE LICENSE NUMBER | LICENSE ISSUING STATE | LICENSE ISSUE DATE (DD/MM/YYYY)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 24)

STATE LICENSE NUMBER | LICENSE ISSUING STATE | LICENSE ISSUE DATE (DD/MM/YYYY)

DO YOU HAVE MORE THAN THREE PARTNERS/ASSOCIATES AT THIS PRACTICE? YES NO

IF MORE THAN THREE, HOW MANY?

Covering Colleagues

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

LIST PRIMARY COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 24)

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 24)

DO YOU HAVE MORE THAN TWO COVERING COLLEAGUES AT THIS PRACTICE? YES NO

IF MORE THAN TWO, HOW MANY?

Section 5 Hospital Affiliations

Admitting Arrangements

DO YOU HAVE HOSPITAL PRIVILEGES?* YES NO

DO YOU HAVE HOSPITAL PRIVILEGES AT MORE THAN ONE HOSPITAL? YES NO

IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5 — Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list primary hospital affiliation then secondary or other current affiliation.

PRIMARY HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (MM/YYYY) | AFFILIATION END DATE (MM/YYYY)

FULL, UNRESTRICTED PRIVILEGES? YES NO

ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (MM/YYYY) | AFFILIATION END DATE (MM/YYYY)

FULL, UNRESTRICTED PRIVILEGES? YES NO

ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6 — Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT
IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION. ☐

CARRIER OR SELF-INSURED NAME* | SELF-INSURED?* ☐ YES ☐ NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* | EFFECTIVE DATE* | EXPIRATION DATE | TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* ☐ YES ☐ NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional Insurance, use the Supplemental Insurance Form on page 21.

CARRIER OR SELF-INSURED NAME | SELF-INSURED? ☐ YES ☐ NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (MM/DD/YYYY) | EFFECTIVE DATE* (MM/YYYY) | EXPIRATION DATE (MM/YYYY) | TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? ☐ YES ☐ NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Section 7 — Work History and References

Military Duty

Are you currently on active military duty or military reserve?* ☐ YES ☐ NO

Work History

Include a chronological work history for the past 10 years, excluding current positions listed in section 4.

A longer period may be required by your dental plan organization.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

Section 7 — Work History and References (Continued)

Work History

Do not list current positions. Those should be listed in Section 4.

Include a chronological work history for the past 10 years.

A longer period may be required by your dental plan organization.

TELEPHONE | FAX

COUNTRY CODE | START DATE (MM/YYYY) | END DATE (MM/YYYY)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MM/YYYY) | END DATE (MM/YYYY)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MM/YYYY) | END DATE (MM/YYYY)

REASON FOR DEPARTURE (IF APPLICABLE)

Section 7 — Work History and References (Continued)

Gaps in Professional / Work History

PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALED.

GAP START DATE (MM/YYYY) **GAP END DATE (MM/YYYY)**

GAP START DATE (MM/YYYY) **GAP END DATE (MM/YYYY)**

GAP START DATE (MM/YYYY) **GAP END DATE (MM/YYYY)**

Section 7 — Work History and References (Continued)

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Code lists are found on pages 24-26. Enter the associated 3-digit code for provider type.

NOTE:

You are required to provide exactly 3 references. Your application will not be complete without this information.

Please check with credentialing entity for any special requirements.

Reference 1

LAST NAME*

FIRST NAME* | PROVIDER TYPE (CODE PG 24)

NUMBER* | STREET* | APT/SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

TELEPHONE | FAX

Reference 2

LAST NAME*

FIRST NAME* | PROVIDER TYPE (CODE PG 24)

NUMBER* | STREET* | APT/SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

TELEPHONE | FAX

Reference 3

LAST NAME*

FIRST NAME* | PROVIDER TYPE (CODE PG 24)

NUMBER* | STREET* | APT/SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

TELEPHONE | FAX

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 — Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 22.

1. ☐ YES ☐ NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*
2. ☐ YES ☐ NO Has there been any challenge to your licensure, registration or certification?*
3. ☐ YES ☐ NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
4. ☐ YES ☐ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
5. ☐ YES ☐ NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations including HMOs, dental plans, or provider organizations?*
6. ☐ YES ☐ NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
7. ☐ YES ☐ NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
8. ☐ YES ☐ NO Have any of your board certifications or eligibility ever been revoked, suspended or voluntarily surrendered?*
9. ☐ YES ☐ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*
10. ☐ YES ☐ NO Do you, or your business entity, own, have an investment in, manage, own stock in, participate in a joint venture, or act as a partner, contract consultant or medical/dental advisor in any medical/dental enterprise or medical/dental supplier outside of your direct practice where you would financially benefit directly or indirectly?*
11. ☐ YES ☐ NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*
12. ☐ YES ☐ NO Are you currently the subject of an investigation by any hospital, licensing authority, education or training program, Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
13. ☐ YES ☐ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
14. ☐ YES ☐ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies?*
15. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*
16. ☐ YES ☐ NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*
17. ☐ YES ☐ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
18. ☐ YES ☐ NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

Section 8 — Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 22.

IMPORTANT
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 23 for each malpractice claim.

19. ☐ YES ☐ NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* If yes, provide information for each case.

20. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*

21. ☐ YES ☐ NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

22. ☐ YES ☐ NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

23. ☐ YES ☐ NO Are you currently engaged in the illegal use of drugs?*
("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice dentistry. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. ☐ YES ☐ NO Do you use any chemical substances that would in any way impair or limit your ability to practice dentistry and perform the functions of your job with reasonable skill and safety?*

25. ☐ YES ☐ NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

26. ☐ YES ☐ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, dental groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, dental or health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, credentialing and accreditation agencies, professional dental societies, state dental boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

DATE SIGNED* (MM/DD/YYYY)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 | **Practice Location Information - Page 1 of 2**

Additional Practice Location

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

LOCATION* #

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

PREVIOUS OR FUTURE START DATE?

DENTAL GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* ☐ YES ☐ NO

TELEPHONE* | FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID | GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* ☐ USE INDIVIDUAL TAX ID ☐ USE GROUP TAX ID

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* | M.I.

TELEPHONE* | FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

LAST NAME*

FIRST NAME* | M.I.

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

TELEPHONE* | FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 | **Practice Location Information - Page 2 of 2**

Add'l Practice Location (Cont.)

LOCATION* #

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

24/7 PHONE COVERAGE?* YES NO

IF YES: ANSWERING SERVICE; VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE; VOICE MAIL WITH OTHER INSTRUCTIONS; COVERING COLLEAGUE

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO

ACCEPT ALL NEW PATIENTS?* YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO

ACCEPT NEW MEDICAID PATIENTS?* YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* YES NO

IF YES, EXPLAIN

CURRENT WAIT TIME FOR INITIAL APPOINTMENT

NUMBER OF OPERATORS AVAILABLE

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Liability Insurance Carrier
Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 | **Professional Liability Insurance Carrier**

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

CARRIER OR SELF-INSURED NAME

SELF-INSURED? YES NO

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

ORIGINAL EFFECTIVE DATE* (MM/YYYY) EFFECTIVE DATE* (MM/YYYY) EXPIRATION DATE (MM/YYYY)

TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO

$ AMOUNT OF COVERAGE PER OCCURRENCE

$ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

CARRIER OR SELF-INSURED NAME

SELF-INSURED? YES NO

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

ORIGINAL EFFECTIVE DATE* (MM/YYYY) EFFECTIVE DATE* (MM/YYYY) EXPIRATION DATE (MM/YYYY)

TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO

$ AMOUNT OF COVERAGE PER OCCURRENCE

$ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

Disclosure Questions
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 | **Disclosure Questions**

Disclosure Questions

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. Your response should not exceed the spaces provided.

Record the question number in the first column, then your explanation in the second column.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Malpractice Claims Explanation
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Malpractice Claims Explanation

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

DATE OF OCCURRENCE* (MM/DD/YYYY)

DATE CLAIM WAS FILED* (MM/DD/YYYY)

STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN)

☐ OPEN ☐ CLOSED

IF SETTLED, ENTER DATE CLAIM WAS SETTLED (MM/DD/YYYY)

PROFESSIONAL LIABILITY CARRIER INVOLVED* (USE BOTH LINES IF NECESSARY)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE POLICY NUMBER

$ AMOUNT OF AWARD OR SETTLEMENT*

METHOD OF RESOLUTION?* ☐ DISMISSED ☐ SETTLED ☐ MEDIATION ☐ ARBITRATION ☐ JUDGMENT FOR DEFENDANT(S) ☐ JUDGMENT FOR PLAINTIFF(S)

DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY)

WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?* ☐ PRIMARY DEFENDANT ☐ CO-DEFENDANT

NUMBER OF OTHER CO-DEFENDANTS (IF ANY)

YOUR INVOLVEMENT IN CASE* (ATTENDING, CONSULTING, ETC)

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT (USE ALL FOUR LINES BELOW, IF NECESSARY)

DID THE ALLEGED INJURY RESULT IN DEATH? ☐ YES ☐ NO

TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?* ☐ YES ☐ NO

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Code Lists

Provider Type Codes

001 Medical Doctor (MD)
002 Doctor of Dental Surgery (DDS)
003 Doctor of Dental Medicine (DMD)
004 Other

License Status Codes

001 Active
002 Canceled
003 Denied
004 Expired
005 Inactive
006 Lapsed
007 Limited
008 Pending
009 Probation
010 Provisional
011 Restricted
012 Revoked
013 Suspended
014 Surrendered
015 Temporary
016 Terminated
017 Time Limited
018 Unrestricted
019 Other

Country Codes

004 Afghanistan
008 Albania
012 Algeria
016 American Samoa
020 Andorra
024 Angola
660 Anguilla
010 Antarctica
028 Antigua and Barbuda
032 Argentina
051 Armenia
533 Aruba
036 Australia
040 Austria
031 Azerbaijan
044 Bahamas
048 Bahrain
050 Bangladesh
052 Barbados
112 Belarus
056 Belgium
084 Belize
204 Benin
060 Bermuda
064 Bhutan
068 Bolivia
070 Bosnia and Herzegovina
072 Botswana
074 Bouvet Island
076 Brazil
086 British Indian Ocean Territory
096 Brunei Darussalam
100 Bulgaria
854 Burkina Faso
108 Burundi
116 Cambodia
120 Cameroon
124 Canada
132 Cape Verde
136 Cayman Islands
140 Central African Republic
148 Chad
152 Chile
156 China
162 Christmas Island
166 Cocos (Keeling) Islands
170 Colombia
174 Comoros
178 Congo
180 Congo, Democratic Republic of the
184 Cook Islands
188 Costa Rica
384 Cote d'Ivoire
191 Croatia
192 Cuba
196 Cyprus
203 Czech Republic
208 Denmark
262 Djibouti
212 Dominica
214 Dominican Republic
626 East Timor (provisional)
218 Ecuador
818 Egypt
222 El Salvador
226 Equatorial Guinea
232 Eritrea
233 Estonia
231 Ethiopia
238 Falkland Islands (Malvinas)
234 Faroe Islands
242 Fiji
246 Finland
250 France
249 France, Metropolitan
254 French Guiana
258 French Polynesia
260 French Southern Territories
266 Gabon
270 Gambia
268 Georgia
276 Germany
288 Ghana
292 Gibraltar
300 Greece
304 Greenland
308 Grenada
312 Guadaloupe
316 Guam
320 Guatemala
324 Guinea
624 Guinea-Bissau
328 Guyana
332 Haiti
334 Heard Island and McDonald Islands
340 Honduras
344 Hong Kong
348 Hungary
352 Iceland
356 India
360 Indonesia
364 Iran
368 Iraq
372 Ireland
376 Israel
380 Italy
388 Jamaica
392 Japan
400 Jordan
398 Kazakhstan
404 Kenya
296 Kiribati
408 Korea, North
410 Korea, South
414 Kuwait
417 Kyrgyzstan
418 Laos
428 Latvia
422 Lebanon
426 Lesotho
430 Liberia
434 Libya
438 Liechtenstein
440 Lithuania
442 Luxembourg
446 Macau
807 Macedonia
450 Madagascar
454 Malawi
458 Malaysia
462 Maldives
466 Mali
470 Malta
584 Marshall Islands
474 Martinique
478 Mauritania
480 Mauritius
175 Mayotte
484 Mexico
583 Micronesia
498 Moldova
492 Monaco
496 Mongolia
500 Montserrat
504 Morocco
508 Mozambique
104 Myanmar
516 Namibia
520 Nauru
524 Nepal
528 Netherlands
530 Netherlands Antilles
540 New Caledonia
554 New Zealand
558 Nicaragua
562 Niger
566 Nigeria
570 Niue
574 Norfolk Island
580 Northern Mariana Islands
578 Norway
512 Oman
586 Pakistan
585 Palau
591 Panama
598 Papua New Guinea
600 Paraguay
604 Peru
608 Philippines
612 Pitcairn
616 Poland
620 Portugal
630 Puerto Rico
634 Qatar
638 Réunion
642 Romania
643 Russian Federation
646 Rwanda
654 Saint Helena
659 Saint Kitts and Nevis
662 Saint Lucia
666 Saint Pierre and Miquelon
670 Saint Vincent and the Grenadines
882 Samoa
674 San Marino
678 São Tomé and Príncipe
682 Saudi Arabia
683 Scotland
686 Senegal
690 Seychelles
694 Sierra Leone
702 Singapore
703 Slovakia
705 Slovenia
090 Solomon Islands
706 Somalia
710 South Africa
239 South Georgia and the South Sandwich Islands
724 Spain
144 Sri Lanka
736 Sudan
740 Suriname
744 Svalbard and Jan Mayen
748 Swaziland
752 Sweden
756 Switzerland
760 Syria
158 Taiwan
762 Tajikistan
834 Tanzania
764 Thailand
768 Togo
772 Tokelau
776 Tonga
780 Trinidad and Tobago
788 Tunisia
792 Turkey
795 Turkmenistan
796 Turks and Caicos Islands
798 Tuvalu
800 Uganda
804 Ukraine
784 United Arab Emirates
826 United Kingdom
840 United States
581 U.S. Minor Outlying Islands
858 Uruguay
860 Uzbekistan
548 Vanuatu
336 Vatican City State (Holy See)
862 Venezuela
704 Viet Nam
092 Virgin Islands, British
850 Virgin Islands, U.S.
876 Wallis and Fortuna Islands
732 Western Sahara (provisional)
887 Yemen
891 Yugoslavia
894 Zambia
716 Zimbabwe

Code Lists

Language Codes

001 Abkhazian
002 Afan (Oromo)
003 Afar
004 Afrikaans
005 Albanian
006 Amharic
007 Arabic
008 Armenian
009 Assamese
010 Zerbaijani
011 Bashkir
012 Basque
013 Bengali;Bangla
014 Bhutani
015 Bihari
016 Bislama
017 Breton
018 Bulgarian
019 Burmese
020 Byelorussian
021 Cambodian
022 Catalan
023 Chinese
024 Corsican
025 Croatian
026 Czech
027 Danish
028 Dutch
140 English
030 Esperonto
031 Estonian
032 Faroese
033 Fiji
034 Finnish
035 French
036 Frisian
037 Galican
038 Georgian
039 German
040 Greek
041 Greenlandic
042 Guarani
043 Gujarati
044 Hausa
045 Hebrew
046 Hindi
047 Hungarian
048 Icelandic
049 Indonesian
050 Interlingua
051 Interlingue
052 Inuktitut
053 Inupiak
054 Irish
055 Italian
056 Japanese
057 Javanese
058 Kannada
059 Kashmiri
060 Kazakh
061 Kinyarwanda
062 Kirghiz
063 Kurundi
064 Korean
065 Kurdish
066 Laothian
067 Latin
068 Latvian;Lettish
069 Lingala
070 Lithuanian
071 Macedonian
072 Malagasy
073 Malay
074 Malayalam
075 Maltese
076 Maori
077 Marathi
078 Moldavian
079 Mongolian
080 Nauru
081 Nepali
082 Norwegian
083 Occitan
084 Oriya
085 Pashto;Pushto
086 Persian (Farsi)
087 Polish
088 Portuguese
089 Punjabi
090 Quechua
091 Rhaeto-Romance
092 Romanian
093 Russian
094 Samoan
095 Sangho
096 Sanskrit
097 Scot Gaelic
098 Serbian
099 Serbo-Croatian
100 Sesotho
101 Setswana
102 Shona
103 Sindhi
104 Singhalese
105 Siswati
106 Slovak
107 Slovenian
108 Somali
109 Spanish
110 Sundanese
111 Swahili
112 Swedish
113 Tagalog
114 Tajik
115 Tamil
116 Tatar
117 Telugu
118 Thai
119 Tibetan
120 Tigrinya
121 Tonga
122 Tsonga
123 Turkish
124 Turkmen
125 Twi
126 Uigur
127 Ukrainian
128 Urdu
129 Uzbek
130 Vietnamese
131 Volapuk
132 Welsh
133 Wolof
134 Xhosa
135 Yiddish
136 Yoruba
10 Zerbaijani
137 Zhuang
138 Zulu

U.S. / Canadian Professional School Codes

Alabama
300 University of Alabama School of Dentistry

Arizona
900 Arizona School of Dentistry and Oral Health

California
301 Loma Linda University School of Dentistry
302 University of California, Los Angeles School of Dentistry
303 University of California, San Francisco, School of Dentistry
304 University of Southern California School of Dentistry
305 University of the Pacific School of Dentistry

Colorado
306 University of Colorado School of Dentistry

Connecticut
307 University of Connecticut School of Dental Medicine

District of Columbia
308 Howard University College of Dentistry

Florida
309 Nova Southeastern University College of Dentistry
310 University of Florida College of Dentistry

Georgia
311 Medical College of Georgia School of Dentistry

Iowa
312 University of Iowa College of Dentistry

Illinois
313 Northwestern University Dental School
314 Southern Illinois University School of Dental Medicine
315 University of Illinois at Chicago College of Dentistry

Indiana
316 Indiana University School of Dentistry

Kentucky
317 University of Kentucky College of Dentistry
318 University of Louisville School of Dentistry

Louisiana
319 Louisiana State University School of Dentistry

Massachusetts
320 Boston University, Goldman School of Dental Medicine
321 Harvard School of Dental Medicine
322 Tufts University School of Dental Medicine

Maryland
323 University of Maryland, Baltimore, College of Dental Surgery

Michigan
324 University of Detroit Mercy School of Dentistry
325 University of Michigan School of Dentistry

Minnesota
326 University of Minnesota School of Dentistry

Missouri
327 University of Missouri Kansas City School of Dentistry

Mississippi
328 University of Mississippi School of Dentistry

North Carolina
329 University of North Carolina at Chapel Hill School of Dentistry

Nebraska
330 Creighton University School of Dentistry
331 University of Nebraska Medical Center, College of Dentistry

Code Lists

U.S. / Canadian Professional School Codes (continued)

Nevada
901 University of Nevada Las Vegas School of Dental Medicine

New Jersey
332 UMDNJ, New Jersey Dental School

New York
333 Columbia University School of Dental and Oral Surgery
334 New York University Kriser Dental Center
335 State University of New York at Buffalo School of Dental Medicine
336 State University of New York at Stony Brook School of Dental Medicine

Ohio
337 Case Western Reserve University School of Dentistry
338 Ohio State University College of Dentistry

Oklahoma
339 University of Oklahoma College of Dentistry

Oregon
340 Oregon Health Sciences University School of Dentistry

Pennsylvania
341 Temple University School of Dentistry
342 University of Pennsylvania School of Dental Medicine
343 University of Pittsburgh School of Dental Medicine

Puerto Rico
344 University of Puerto Rico School of Dentistry

Rhode Island

South Carolina
345 Medical University of South Carolina College of Dental Medicine

South Dakota

Tennessee
346 Meharry Medical College School of Dentistry
347 University of Tennessee College of Dentistry

Texas
348 Baylor College of Dentistry
349 University of Texas Health Science Center at Houston Dental School
350 University of Texas Health Science Center at San Antonio Dental School

Virginia
351 Virginia Commonwealth University School of Dentistry

Washington
352 University of Washington School of Dentistry

Wisconsin
353 Marquette University School of Dentistry

West Virginia
354 West Virginia University School of Dentistry

Canada
355 Dalhousie University Faculty of Dentistry
357 Laval University Faculty of Dentistry
356 McGill University Faculty of Dentistry
132 The University of Western Ontario Faculty of Medicine & Dentistry
358 University of Alberta Faculty of Dentistry
359 University of British Columbia Faculty of Dentistry
360 University of Manitoba Faculty of Dentistry
138 University of Manitoba Faculty of Medicine
361 University of Montreal Faculty of Dentistry
362 University of Saskatchewan College of Dentistry
363 University of Toronto Faculty of Dentistry
364 University of Western Ontario Faculty of Dentistry

Other
999

Specialty Codes - DDS / DMD

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

DDS / DMD
2 Dentist
13 Dentist, Dental Public Health
14 Dentist, Endodontics
438 Dentist, General Practice
16 Dentist, Oral and Maxillofacial Pathology
439 Dentist, Oral and Maxillofacial Radiology
20 Dentist, Oral and Maxillofacial Surgery
15 Dentist, Orthodontics and Dentofacial Orthopedics
17 Dentist, Pediatric Dentistry
18 Dentist, Periodontics
19 Dentist, Prosthodontics
99 Other

Specialty Boards - Dental

113 American Board of Endodontics
114 American Board of Oral & Maxillofacial Pathology
117 American Board of Oral & Maxillofacial Radiology
109 American Board of Oral & Maxillofacial Surgeons
108 American Board of Orthodontics
112 American Board of Pediatric Dentistry
111 American Board of Periodontology
115 American Board of Prosthodontics
106 American Board of Public Health Dentistry
120 Boards other than ABMS/AOA