DeCare Dental Networks, LLC
Attn: National Credentialing
PO Box 1175 Minneapolis, MN 55440-1175
Phone # 800-658-4187 ext 5364 Fax # 866-286-8840

DEMOGRAPHICS *(Please type or print)* ***STATE DENTAL LICENSE #:*** _____*(submit copy)*

Name:	_____ Last First MI
Social Security Number:	___ ___ ___ - ___ ___ - ___ ___ ___ ___
Individual NPI:	___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___ (Type 1 NPI only)
Date of Birth:	___ ___ / ___ ___ / ___ ___ ___ ___ Do you currently hold a DEA registration? ☐ Yes ☐ No (Submit copy)
Gender:	☐ Male ☐ Female
Languages Spoken Fluently:	_____
Home Address and Phone:	_____(_____)_____

PRIMARY PRACTICE LOCATION

Primary Office:	_____ Group Name and Clinic Name (if different)
Street Address:	_____
City/State/Zip:	_____ County:_____
Office Phone Number:	(_____)_____ ER/After Hours Number: (_____)_____
Fax Number:	(_____)_____
Tax ID Number (TIN):	___ ___ - ___ ___ ___ ___ ___ ___ ___
Corporate NPI:	___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___
Office Manager/Contact:	_____ Office Email:_____
	If **more than one location** please **attach a separate sheet** with the above information.

BILLING INFORMATION *(If different from information given above)*

Billing Name:	_____
Billing Address:	_____ County:_____
Office Manager/Contact:	_____
Billing Phone Number:	(_____)_____
Billing Tax ID Number (TIN):	___ ___ - ___ ___ ___ ___ ___ ___ ___

GENERAL DENTISTRY EDUCATION

Institution	Grad Date	Degree

SPECIALTY EDUCATION

Institution	Specialty	Grad Date	Degree

For the above specialty, I am: ☐ Educationally Qualified (**attach copy of specialty certificate**)
☐ **Board Certified * (attach copy of certificate** from Specialty **Board**)
* Date of Certification:_____ Expiration Date: _____

DISCLOSURE QUESTIONS

Please complete the Professional Liability Addendum in this application if any of the following questions are answered in the affirmative.

1. ☐Yes ☐No Is your dental license in the state in which you practice currently limited, suspended or revoked?
2. ☐Yes ☐No Has a professional entity (licensing board, Medicare/Medicaid, DEA, Hospital) ever stipulated, restricted, revoked, suspended or in any way limited you or your practice?
3. ☐Yes ☐No Have you ever had any malpractice (professional liability) claims or lawsuits brought against you (includes pending or dismissed claims or lawsuits, settlements or final judgments)?
4. ☐Yes ☐No Is your Professional Liability current with limits of $1million/$3 million?

PROFESSIONAL LIABILITY ADDENDUM

(Fill out in its entirety or attach copy)

Professional Liability Carrier: _____ **Policy Limits:** _____

PL Expiration Date: _____ **Policy Number:** _____

COMPLETE ONLY IF you answered "YES" to any Disclosure Questions.
Attach separate sheet if necessary.

Malpractice Claim(s) / Board Action(s)

Date of Occurrence: _____ Settlement Amount/Fine Pd: _____

Name & Address of Insurance Carrier _____

Current Status of Claim/Action: _____ Date Claim/Action Resolved: _____

Details of Allegations / Details of Action (conditions, limitations, etc.) Attach copy of Board Action/Corrective Action:

_____

_____

_____

DISCLOSURE QUESTIONS AND PROVIDER CONSENT

I certify that the information furnished on the DeCare Dental Networks, LLC (DDN) *Application for Contracting* is complete and accurate. I acknowledge that my eligibility to become a participating dentist is contingent upon the provision of complete and accurate information in this application and successful completion of credentialing. I agree to inform DDN within ten (10) days of notice of any material changes in such information, whether before or after entering into an agreement with DDN for the provision of dental services. I agree to notify DDN of any changes in malpractice coverage, including the insurance carrier and policy number within ten (10) days of the date any such changes occur. I certify that my office protocols for infection control are in compliance with current CDC/OSHA guidelines. I understand that my application may require DDN to review 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/Healthcare Integrity and Protection Data Bank administered by the U.S. Government. I hereby consent to and authorize the release of such information by any such entity that requires authorization. I authorize photocopies of this authorization to be used by DDN.

Signature _____ **Date** _____

Name _____
(please print or type)

Notice of Applicant's Right

You may review 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 to 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-Healthcare Integrity Protection Data Bank.

DeCare Dental Networks, LLC maintains all information gathered as part of the credentialing/re-credentialing process in a confidential manner and will not communicate or reproduce any information obtained during the process. DDN strictly enforces the provisions designed to safeguard information and ensure confidentiality. DeCare Dental LLC's selection process insures 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.