DeCare Dental℠ NETWORKS

CREDENTIALING APPLICATION

EASY AS 1, 2, 3!!!

1. Complete the simple application, including consent form: sign and date.
   (DDN does NOT accept STAMPED signatures)

2. Make copies of the supporting documents listed below:
   - ✓ W-9 Form or Taxpayer Identification Number Request
   - ✓ Additional Locations (please attach a separate sheet with practice information)
   - ✓ Dental License (provide copies for EVERY state in which you are licensed)
   - ✓ **Federal** DEA Registration for **EVERY STATE** the DDS is practicing in (or documentation DEA is pending)
   - ✓ **American** Board/Specialty Certificate (if applicable)
   - ✓ Professional Liability Insurance Declaration Page for each State in which you practice – showing insurance carrier, dentist's name, policy #, effective and expiration dates and coverage limits of no less than $1million/$3 million. (If expiration date is within weeks of this application, updated documentation must be submitted)

3. Mail the application along with a signed DeCare Dental Networks, LLC Contracting Dentist Agreement to:

DeCare Dental Networks, LLC
Attn: National Credentialing
P.O. Box 1175
Minneapolis, MN 55440-1175

OR, *TO EXPEDITE*, APPLICATION CAN BE FAXED TO:

FAX: (866) 286-8840
QUESTIONS? Call (866) 462-1832 x5364

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

DeCare Dental Networks, LLC (DDN) maintains all information gathered as part of the credentialing or 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 Networks, LLC
Attn: National Credentialing
PO Box 1175 Minneapolis, MN 55440-1175
Phone # 866-462-1832 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:	___ ___ / ___ ___ / ___ ___ ___ ___ Gender ☐ Male ☐ Female
Federal DEA:	Do you currently hold a **Federal DEA** registration in each State you practice? ☐ Yes (Submit copy) ☐ No **If DEA app has been submitted and is PENDING,** DDS will not write prescriptions until DEA is finalized. DDS' Initials_____
Languages Spoken Fluently:	_____
Home Address and Phone:	_____(_____)_____

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

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): (As listed on W-9)	___ ___ - ___ ___ ___ ___ ___ ___ ___
Corporate NPI:	___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___
Office Manager/Contact:	Office Email:

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 (Submit Copy if Applicable)

Institution	Specialty	Grad Date	Degree

For the above specialty, I am:
☐ Educationally Qualified (**attach copy** of specialty certificate **showing institution name, grad yr, and specialty)**
☐ **Board Certified * (ATTACH COPY** of certificate **from the American Board)**
*Date of Certification:_____ Expiration Date: _____

DISCLOSURE QUESTIONS

Please complete the Disclosure Question Explanation in this application if questions 1, 2 or 3 are answered in the affirmative.

1. ☐Yes ☐No Is your dental license currently limited, suspended or revoked in the state in which you practice?
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, including corrective action?
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 INSURANCE

for **each state** in which you practice **(Complete below or attach copy of Professional Liability Insurance)**

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

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

Disclosure Question Explanation

COMPLETE ONLY IF you answered "YES" to Disclosure Questions #1, #2 or #3.
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. 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.