

Provider Application (please complete for each dentist)

Practitioner Information

Note: **Dentist Name is required as it appears on dental license and this name should be used for claim submission.** Dentists applying for participation in the network(s) under a participating practice's Dental Provider Agreement agree to be bound by those same terms and conditions of the Dental Provider Agreement and any associated protocols therein.

First Name:		MI:	Last Name:		<input type="checkbox"/> DDS <input type="checkbox"/> DMD	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Associate <input type="checkbox"/> Owner
Date Of Birth: / /	SSN:	NPI No. (Type 1/Individual):	Medicaid No. (Individual):	Medicaid No. (Site):	Name as it appears on Dental Degree:		
Dentist Non-English Language(s)					Dentist E-mail Address:		

Specialty: General Dentist Endodontist Oral Surgeon Orthodontist Pediatric Dentist Periodontist Prosthodontist
 Dental Anesthesiologist

License and Registration Information (*Current copies must be sent with application.)

State: *Dental License No.:	*Drug Enforcement Agency (DEA) No.:	*Controlled Dangerous Substance (CDS) No., if applicable:
-----------------------------	-------------------------------------	---

Additional Dental License Numbers (active or inactive)

State: Dental License No.:	State: Dental License No.:	State: Dental License No.:	State: Dental License No.:
----------------------------	----------------------------	----------------------------	----------------------------

Professional Liability Coverage (malpractice)

<input type="checkbox"/> Prof. Liability Ins.	Carrier:	Per Claim Amt.:	Eff. Date: / /
<input type="checkbox"/> Fed. / State Tort Cov.	Policy / FTCA No.:	Aggregate Amt.:	Exp. Date: / /

Education and Training

Full Name of U.S. Dental School:		Graduation Mo/Yr:
Address:		City: State:

Country of Dental School: United States Other, please list country:
For dental training outside the U.S., show the State requirements that have been met allowing you to practice in the U.S. and the accredited organization attended:

Specialty Training / Residency

Name of Institution:		Completion Mo/Yr:
Address:		City: State:

Training: Endodontist Oral Surgeon Orthodontist Pediatric Dentist Periodontist Prosthodontist Dental Anesthesiologist

Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Certifying Board Name:	Last Certification Year:
---	------------------------	--------------------------

5 Year Professional Work Experience (Beginning with current / must list month and year.)

Name of Practice	Location (City, State, Country)	Month/Year Started	Month/Year Ended

Work history gaps greater than 6 months must be explained:

Provider Application (please complete for each dentist)	Practitioner Name:
--	---------------------------

Professional Questions and Attestation

For each "YES" response, please provide a detailed/clinical explanation below. (An incorrect answer, or failure to provide an explanation, may delay the credentialing process.)		Yes	No
1.	Have there ever been actions against or investigations relating to your professional license(s) in any jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have there ever been any actions against or investigations relating to your hospital, DHMO and/or health/managed care plan privileges?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you had any actions against or investigations relating to your DEA registration and/or CDS certification within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever voluntarily or involuntarily surrendered your license, DEA registration, CDS certificate, or hospital, DHMO or health/managed care privileges?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are there currently any restrictions on your license or limitations on your scope of practice?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you been named in, or had a judgment or settlement in a malpractice action within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you been without professional liability insurance coverage in the past five consecutive years (Massachusetts: past ten consecutive years?) or has coverage ever been denied, suspended, modified, canceled, limited to exclude specific procedures, or not renewed by the action of any insurance company?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever been convicted of a felony or named as a defendant in any past or pending criminal proceeding, excluding traffic violations? If yes, explain all occurrences and include arrest disposition.	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you ever been sanctioned or disciplined by a professional organization (to include a request to surrender membership)?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Has there ever been any disciplinary action, suspension, probation, formal reprimand or request to resign during your education, internship, residency, fellowship, or other applicable training, including board certification?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has an adverse action been filed against you or have you received any disciplinary procedures regarding your participation in any private, state, or federal insurance program?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Is there anything that would prevent you from being able to competently perform essential job-related functions without risk to patient safety or health, with or without reasonable accommodation?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Are you currently using illegal substances or are you dependent on alcohol, drugs, or illegal substances?	<input type="checkbox"/>	<input type="checkbox"/>

Affirmative answer explanation: If additional space is needed, please attach explanation on separate sheet.

Question #	
------------	--

Question #	
------------	--

Attestation/Consent and Release Form

I hereby give permission to Plan/Network, directly and/or through a third-party designee, to request information regarding my professional credentials and qualifications from educational facilities, the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, federal and state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.

The information requested may include otherwise privileged or confidential material relative to my qualifications, credentials, claims history, clinical competence, character, ethics, or any other matter applicable to the credentialing procedure. I release and agree to hold harmless the Plan/Network and its third-party designee, and their respective representatives from all liability for any damages or costs resulting from the gathering or good faith use of the information provided.

I hereby authorize the education facilities, hospital(s) in which I currently have or formerly have had privileges, professional certification boards, federal and state regulatory and licensing departments, malpractice insurance carriers, other professional monitoring entities, and present and past employers to submit information requested by Plan/Network, directly and/or through its third-party designee. If applicable, I authorize the Physician Recovery Network or applicable recovery program to release to Plan/Network information regarding my health status and participation status in any treatment program(s). I further release and agree to hold harmless all entities and their representatives referenced above from all liability related to the provision of information as long as such provision is done in good faith and without malice.

I agree that the photocopy/facsimile of this document with my signature may be accepted by any person or entity from which information is sought with the same authority as the original, and I waive written notice from any such entities or individuals who may provide information.

I understand that a condition of this application is that any misrepresentation or omission from this application, whether intentional or not, is a cause for rejection by Plan/Network and may result in termination if participation has been awarded to me. I agree to use my best efforts to inform Plan/Network in writing within 15 days if there is any change in the information provided or the answers to questions on the application as a result of developments subsequent to my signing this application.

I warrant that I have the authority to sign this application, on my behalf, and on behalf of any entity/practice for which I am signing as a representative.

If I am accepted for participation, I consent to the inspection of my patient records for Plan Members as necessary for peer and utilization review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual.

I understand that I have the right to review and correct erroneous information obtained by Plan/Network to evaluate my application, including information obtained from primary sources such as insurance carriers, licensing boards, or the National Practitioner Data Bank (NPDB). The review must take place within 6 months of application submittal. Corrections must be made in writing within 30 days of the review. This does not require Plan/Network to divulge references or other peer review protected information.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Plan/Network may report the rejection to the appropriate licensing board, NPDB and/or Health Care Integrity and Protection Data Bank.

I represent the information provided in or attached to this application is accurate and complete. I attest to having adequate current malpractice insurance for the state(s) in which I practice. I certify that I hold a full, unrestricted license to practice in the state in which I reside or I have indicated on this application the limitations and/or restrictions imposed.

This health care organization, and its third-party designee, does not discriminate on the basis of race, color, national origin, sex, relation, age or disability.

Your signature is required to complete this document. Stamped signatures are not acceptable.

Practitioner Name (Printed)

Practitioner Signature

Date (MM/DD/YYYY)

Location Information			Practitioner Name:		
Practice Name:			Name of Owner(s):		
Primary Office Address:		Suite:	City:	State:	ZIP:
County	Office Phone No.: ()	Office Fax No.: ()	Tax ID (Submit W-9 form):		
Month/Year Start Date: /		Will a patient be able to routinely book an appointment with you at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mailing Address (if different from primary):		Suite:	City:	State:	ZIP:
NPI No. (Type 2/Organization):	Group Medicaid ID:	For Medicaid only: Please indicate the NPI Number that was registered with the State as the Billing NPI number for this location:			
Office E-mail Address (Directory Publication):		Allow UnitedHealthcare to display Office E-mail Address in directories if intended for patient communication, regularly monitored and meets State/Federal health privacy laws. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Office E-mail Address for UnitedHealthcare Correspondence:			Office Website:		

Facility Type (Check all that apply for this location):

Private Practice
 Essential Community Provider (ECP)
 Portable Dental Operations (PDO)
 Dental School Based Practice
 Health Department (HD)
 Federally Qualified Health Center (FQHC)
 Mobile Dental Facility (MDF)
 Hospital Based Practice
 Urban Indian (UI)
 School Based Health Center (SBHC)
 Indian Services Provider (ISP)
 Community Health Center (CHC)

Is your office on or near a public transportation line? Yes No Is your office handicap accessible? Yes No

Are you able to treat: Special needs patients? Yes No List Patient Age Limits: Minimum Age: _____
Wheelchair confined patients? Yes No Maximum Age: _____

Office Staff Non-English Language(s):

Office Hours						
Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:

Sedation/Anesthesia Information (applies to dentists only; not applicable to local anesthesia)

1. Are any forms of sedation and/or general anesthesia administered **by anyone** in your practice location? Yes No
(Refer to CDT codes under Section 1, XII. Adjunctive General Services, Anesthesia. If yes, please continue to question 2. If no, do not complete 2 to 5)

2. Do you have healthcare clinicians (DDS, MD, CRNA), **other than yourself**, providing sedation and/or general anesthesia on patients you are treating at your practice location? Yes No

3. Do **you** administer any form of sedation and/or general anesthesia? Yes No
(If yes, please continue to 4 and 5 and sign and date below. If no, do not complete 4 and 5, signature not required below.)

4. Please select the type(s) of sedation you (the applicant) administer and provide your applicable permit/license information below:

Deep Sedation/General Anesthesia Permit/License # _____ Exp. Date: / / State: ___ No state-issued permit/license
 Moderate/Conscious Sedation (all types) Permit/License # _____ Exp. Date: / / State: ___ No state-issued permit/license
 Minimal Sedation (all types) Permit/License # _____ Exp. Date: / / State: ___ No state-issued permit/license
 Pediatric Moderate/Conscious Sedation (all types) Permit/License # _____ Exp. Date: / / State: ___ No state-issued permit/license
 Nitrous Oxide Permit/License # _____ Exp. Date: / / State: ___ No state-issued permit/license
 Other Sedation Type: _____ Permit/License # _____ Exp. Date: / / State: ___ No state-issued permit/license

5. Please select if you are an Owner or Associate and sign and date below:

Owner: Please confirm that you comply with and have verified that each of those individuals providing patients with any form or level of sedation, anesthesia and/or nitrous oxide comply with all State requirements, including, but not limited to, those regarding equipment, supplies and training.
 Associate: Please confirm that you comply with all State requirements in providing patients with any form or level of sedation, anesthesia and/or nitrous oxide, including, but not limited to, those regarding equipment, supplies and training.

Practitioner Signature: _____ Date: / /

Please send completed applications along with current copies of all other required documents

Name: _____ E-mail: _____ Phone: _____
Address: _____ Fax: _____

NOTE: A Dental Provider Agreement is required, if not already on file for this practice.