North Carolina Credentialing/Recredentialing Application Checklist

INCOMPLETE APPLICATIONS WILL BE RETURNED, WHICH WILL DELAY THE CREDENTIALING/RECREDENTIALING PROCESS

1. The attached Credentialing / Recredentialing Application is required.
2. Complete, sign, and date the forms.
3. Required fields will be outlined in red and **must** be completed in order to submit your application.
4. All applicable, non-required fields **must** be completed in order for the application to be accepted.
5. If you need additional space to complete a section, attach additional sheets.
6. If you answer "Yes" to any disclosure questions in the Credentialing/ Recredentialing Application, you MUST provide detailed information concerning the item.
7. During the initial credentialing process, you must include a signed copy of any agreement(s), *if applicable*.
8. A current copy of the declaration of coverage or certificate of coverage for your professional liability insurance policy which indicates carrier name, policy number, expiration dates and policy limits must be sent with the recredentialing application.
9. A copy of professional liability claims history for the past five (5) years (if none please state such) and a list of any sanctions imposed by Medicare, Medicaid, and/or any state Board of Dentistry must be sent with the credentialing application.
10. A copy of current license, DEA certificate and completed W-9 must be submitted along with both the credentialing and recredentialing application.
11. Delta Dental will verify Professional License(s), Certifications and Education experience.
12. Specialists must include a copy of their residency/specialty certificate during the initial credentialing process.

****PROVIDERS CANNOT BEGIN TO TREAT ENROLLEES UNTIL A WELCOME LETTER FROM DELTA DENTAL IS RECEIVED****

Delta Dental Provider Credentialing Process

Credentialing is the process of verifying credentials (i.e. training, licensing, Office of Inspector General (OIG) exclusions, National Practitioner Data Bank (NPDB), hospital affiliations, etc.) of potential providers by primary sources. Delta Dental takes pride in its network of providers and credentialing follows the guidelines required by the state and federal law to ensure enrollees are receiving the best quality care possible.

A copy of Delta Dental's Processing Policies is available upon request by calling: 800-524-0149

DEMOGRAPHICS **STATE DENTAL LICENSE #_____**

Name: _____
Last First MI

Maiden/Former/Other Name: _____
Last First MI

Social Security Number: ___-___-___

Individual NPI: _____

Date of Birth: ___/___/___

Gender: ☐ Male ☐ Female

Languages Spoken Fluently: _____

Home Address and Phone: _____

Do you currently hold a DEA registration? Yes ☐ No ☐

If *yes*, federal DEA#: _____

If DEA is PENDING: Above DDS will not write prescriptions until DEA is finalized. _____(DDS' Initials)

If *no* or *pending*, please list the name and license number of the covering practitioner who will be prescribing on the practitioner's behalf:

Name: _____ DEA #: _____

PRIMARY PRACTICE LOCATION

Primary Office: _____
Group Name and Clinic Name (if different)

Start Date: ___/___/___

Street Address: _____

City/State/ZIP: _____County:_____

Business Web Address: _____

Office Phone Number: (_____)_____ Accepts New Patients ☐ Yes ☐ No

Fax Number: (_____)_____ Handicap Accessible ☐ Yes ☐ No

Tax ID Number (TIN): _____ Treats Disabled Children ☐ Yes ☐ No

Corporate NPI: _____ Treats Disabled Adults ☐ Yes ☐ No

Office Hours: Indicate AM/PM

Public Transit ☐ Yes ☐ No

Monday _____ to _____ Friday _____to _____

Tuesday _____ to _____ Saturday _____to _____

Wednesday _____ to _____ Sunday _____to _____

Thursday _____ to _____

Do you have coverage after normal business hours? ☐Yes ☐No

ER/After Hours Number: (_____)_____

Office Manager/Contact: _____ Office email:_____

If more than one location please submit a separate sheet with the above information.

BILLING INFORMATION (If different from information given above)

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

LICENSES

State License Number(s)	
Are you currently practicing in this State	
List all States that you are licensed with and have been licensed with in the past 5 years	Do you prescribe controlled or non-controlled substances? ☐ Yes ☐ No

PROFESSIONAL LIABILITY

Professional Liability Insurance	
Amount of coverage	
Policy Number	
Effective date	
Expiration date	
	Submit a copy of the Professional Liability Insurance Declaration Page reflecting this information.

CERTIFICATIONS AND REGISTRATIONS

List all current and prior Certifications	
List all current and prior Registrations	
	If you have additional Certifications and Registrations submit a separate sheet with that information.

PROFESSIONAL AFFILIATIONS

Please list all Professional Affiliations you belong to	

EDUCATION AND TRAINING

Undergraduate School	Dates Attended:
City/State/ ZIP	
*Other Schools Attended	Dates Attended:
Street Address	
City/State/ ZIP	
	*If attended additional schools submit a separate sheet with that information
*List training program	
Dates attended	
Street Address	
City/State/ZIP	
	*If more than one training program submit a separate sheet with that information.

HOSPITAL PRIVILEGES/WORK HISTORY

Name/Address of Primary Hospital:	Do you have hospital privileges? ☐ Yes ☐ No

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 certificate copy from Specialty **Board**)

* Date of Certification: _____/_____/_____ Expiration Date: _____/_____/_____

WORK HISTORY – Please document all work history for the past 5 years, do not leave any gaps in chronology. If applicable, provide an explanation for any work gap(s) identified.

Practice/Employer Name	______________________________
Street Address	______________________________
City/State/ZIP	______________________________
Country	______________________________
Phone Number	(______)______________________
Start Date	_____/_____/_____
End Date	_____/_____/_____
Reason for Departure	______________________________
Practice/Employer Name	______________________________
Street Address	______________________________
City/State/ZIP	______________________________
Country	______________________________
Phone Number	(______)______________________
Start Date	_____/_____/_____
End Date	_____/_____/_____
Reason for Departure	______________________________
Practice/Employer Name	______________________________
Street Address	______________________________
City/State/ZIP	______________________________
Country	______________________________
Phone Number	(______)______________________
Start Date	_____/_____/_____
End Date	_____/_____/_____
Reason for Departure	______________________________
Practice/Employer Name	______________________________
Street Address	______________________________
City/State/ZIP	______________________________
Country	______________________________
Phone Number	(______)______________________
Start Date	_____/_____/_____
End Date	_____/_____/_____
Reason for Departure	______________________________ **If additional work history is applicable, submit a separate sheet with that information**.

DISCLOSURE QUESTIONS

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

If you are completing this application for recredentialing, please answer the below questions for the past 5 years

1. ☐ Yes ☐ No Have you ever had any Malpractice (Professional Liability) claims or lawsuits brought against you, including pending, dismissed or dropped claims/lawsuits, settlements or final judgments? (This includes status of any pending claims previously reported.) Have you ever had your Malpractice (Professional Liability) carrier refuse or cancel your coverage? If so, provide explanation below in Malpractice Claims.

2. ☐ Yes ☐ No Have you ever had your **professional license, registration or DEA** terminated, stipulated, restricted, limited conditioned, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board or any health-related agency organization, or is there a review pending?

3. ☐ Yes ☐ No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you been subject to a corrective action agreement/plan with any **licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**

4. ☐ Yes ☐ No Have you ever had your certificate or participation in **any private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

5. ☐ Yes ☐ No Have you ever voluntarily/involuntarily relinquished your **membership, participation, clinical privileges or request for privileges, employment, professional license, or registration** as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?

6. ☐ Yes ☐ No Are there any **charges pending** or have you ever been indicted, found guilty of a felony, misdemeanor (other than a minor traffic violation), or other offenses?

7. ☐ Yes ☐ No Are you currently addicted to or excessively use alcohol, drugs or toxic or foreign agents that tend to, in the reasonable judgment of DDNC, limit or adversely affect the performance of your professional duties and responsibilities?

8. ☐ Yes ☐ No Do you have a condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing a significant health or safety risk to your patients?

9. ☐ Yes ☐ No Have you ever had your **membership, participation, clinical privileges, or employment** denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

10. ☐ Yes ☐ No Are you currently using illegal drugs or an unlawful use of prescription controlled substances?

11. ☐ Yes ☐ No 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, with accepted standards of professional performance and without posing a direct threat to patients?

12. ☐ Yes ☐ No Have you ever been found liable, guilty, or responsible for sexual impropriety or misconduct or sexual harassment?

PROFESSIONAL LIABILITY ADDENDUM

Complete addendum if you answered "YES" to any Disclosure Questions.
Attach separate sheet if necessary.

☐ Check this box if you have no liability or malpractice claims history to disclose

Malpractice Claim(s)

Date of Occurrence:_____ Settlement Amount:_____

Name & Address of Insurance Carrier_____

Current Status of Claim:_____ Date Claim Resolved:_____

Details of Allegations:_____

_____

_____

Board Action(s)

Date of Occurrence:_____ Date of Satisfaction/Closure:_____ Amount of Fine Paid:_____

Details of Action (conditions, limitations, etc.):_____

_____

_____

_____

Attach copy of Board Action/Corrective Action

Compliance & Insurance (Attach Copy)

☐ Yes ☐ No 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?

☐ Yes ☐ No Do you have current professional malpractice insurance coverage and agree to maintain continuous, uninterrupted coverage while participating in this program? Please note that under the terms of participation you further agree to notify Delta Dental immediately of any policy cancellation, lapse in coverage, reduction in coverage maximum(s) or claims made.

☐ Yes ☐ No Do you have current general liability coverage and agree to maintain continuous, uninterrupted coverage while participating in this program? Please note that under the terms of participation you further agree to notify Delta Dental immediately of any policy cancellation, lapse in coverage, reduction in coverage maximums(s) or claims made.

☐ Yes ☐ No Has your professional liability insurance ever been denied, suspended, revoked, canceled or not renewed?

Office Information

☐ Yes ☐ No Does facility provide services for children with complex medical or behavioral conditions?

☐ Yes ☐ No Does facility provide sedation for children who may have difficulty communicating or cooperating?

☐ Yes ☐ No Does facility provide interpreter services?

Does facility accommodate the following individuals?

☐ Yes ☐ No Physically disabled

☐ Yes ☐ No Intellectually and/or cognitively disabled

☐ Yes ☐ No Blind or visually impaired

☐ Yes ☐ No Deaf or hard of hearing

Do you have experience in providing dental services to the following:

- □ Yes □ No Persons with physical disabilities
- □ Yes □ No Persons suffering from chronic illness, including HIV or AIDS
- □ Yes □ No Persons suffering from mental illness
- □ Yes □ No Persons who are hearing impaired
- □ Yes □ No Persons who are vision impaired
- □ Yes □ No Persons who are homeless
- □ Yes □ No Children with physical disabilities

Explanation _____

Professional Attestation & Release		
Dentist first name (please print)	Middle initial	Last name
Dentist date of birth	Dentist license number	State issuing license

- I authorize the state board (or other dental licensing agencies in any state in which I am licensed to practice dentistry) to release any information regarding my license to Delta Dental.
- I authorize all universities or dental schools that I have attended to release any degrees or relevant transcripts to Delta Dental.
- I authorize the health care facility or professional organization with whom I was previously employed to release any information regarding my employment to Delta Dental.
- I authorize and request my insurance carrier(s) to release information regarding my current coverage and any claims or actions for damages pending or closed during the previous 10 years, whether or not there has been a final disposition, to Delta Dental.

I release from liability any person or entity who, in good faith and without malice, provides information to Delta Dental for the purpose of evaluating my provider participation application, credentials and qualifications. Further, I release Delta Dental for their acts performed in good faith and without malice, in connection with the evaluation of my provider participation application, credentials and qualifications.

I authorize Delta Dental to consult with any other persons or entities that are necessary in order for Delta Dental to evaluate my professional qualifications including competence, ethics and other qualifications.

I certify that all of the information provided is complete and correct to the best of my knowledge and agree to notify Delta Dental, in writing, of any changes in this document within 10 days of their occurrence. I understand that information that is found to be false could result in denial/termination of participation status with Delta Dental.

I understand that I have the opportunity to review the information submitted in support of this application. If during the process of credentialing, Delta Dental receives information that varies substantially from information I have provided, I will be notified of this and will have the opportunity to correct erroneous information. I have the right, upon request, to be informed of the status of my application.

Delta Dental shall not release any information obtained as part of the credentialing/recredentialing process with prior authorization from the dentist unless otherwise permitted or required by law.

A copy of this attestation and release is valid.

_____
Dentist full name (please print)

_____ _____
Dentist signature Date

Primary Location Supplemental Form

A Provider will only be listed in our Provider directories at his or her Primary Practice Locations.
Providers will remain credentialed at all locations to allow for claims processing.
If you have additional practice locations, please list them below. If you need to list additional locations, please make a copy of this form.

Note: A Primary Practice Location is defined as a location where you are scheduled to see Delta Dental patients at least one day per month. You can have multiple Primary Practice Locations.

Is this a Primary Practice Location? ☐ Y ☐ N

Practice Name: ______________________________ TIN: ____
Service Office Address: ____

Is this a Primary Practice Location? ☐ Y ☐ N

Practice Name: ______________________________ TIN: ____
Service Office Address: ____

Is this a Primary Practice Location? ☐ Y ☐ N

Practice Name: ______________________________ TIN: ____
Service Office Address: ____

Is this a Primary Practice Location? ☐ Y ☐ N

Practice Name: ______________________________ TIN: ____
Service Office Address: ____

Is this a Primary Practice Location? ☐ Y ☐ N

Practice Name: ______________________________ TIN: ____
Service Office Address: ____

Is this a Primary Practice Location? ☐ Y ☐ N

Practice Name: ______________________________ TIN: ____
Service Office Address: ____

Is this a Primary Practice Location? ☐ Y ☐ N

Practice Name: ______________________________ TIN: ____
Service Office Address: ____