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. If you need additional space to complete a section, attach additional sheets.
4. If a question does not apply indicate with "N/A". NOTE: Do not leave blank as we will assume the question was unanswered and the form will be returned to you for completion.
5. If you answer "yes" to any questions in the Credentialing/Recredentialing Application, you MUST provide detailed information concerning the item.
6. During the initial credentialing process, you must include a signed copy of the Premier agreement and PPO agreement, if applicable.
7. ***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.***
8. 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.
9. ***A copy of current license and DEA certificate must be submitted along with both the credentialing and recredentialing application.***
10. Delta Dental will verify Professional License(s), Certifications and Education experience.
11. **Specialists must include a copy of their residency/specialty certificate during the initial credentialing process**.
12. Please be advised, that a site review may be required as part of the recredentialing process for the governmental sponsored programs.

Fax the completed forms to (888) 404-8725 or send to address below or email to

ProviderRequests@deltadentalmi.com

Provider Records
Delta Dental Plan
P.O. Box 30416
Lansing, MI 48909-7916

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

Name: _____
Last First MI

Social Security Number: _____-_____-_____

Individual NPI: _____-_____-_____

Date of Birth: _____/_____/_____ Do you currently hold a DEA registration? ☐ Yes ☐ No

Federal DEA # _____

If DEA is PENDING: Above DDS will not write prescriptions until DEA is finalized. _____

Gender: ☐ Male ☐ Female DDS' Initials

Languages Spoken Fluently: _____

Home Address and Phone: _____

_____

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

Public Transit ☐ Yes ☐ No

Office Hours:

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	
Are you currently practicing in this State	
List all States that you are licensed with and have been licensed with in the past	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	
Street Address	
City/State/ ZIP	
*Other Schools 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

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 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.

1. ☐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 of any health-related agency or organization, or is there a review pending?

2. ☐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?

3. ☐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?

4. ☐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?**

5. ☐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?

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 involving fraud, misrepresentation, dishonesty or deceit? Are you currently using illegal drugs?

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

8. ☐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?

9. ☐Yes ☐No Do you have a condition in 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?

PROFESSIONAL LIABILITY ADDENDUM

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

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:_____

_____

_____

_____

DISCLOSURE QUESTIONS & PROVIDER CONSENT

I hereby certify that to my knowledge that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains so while my application is being processed. I certify that my office protocols for infection control are in compliance with current CDC/OSHA guidelines. I agree to notify Delta Dental of North Carolina of any changes in malpractice coverage, including changes in the insurance carrier or policy number, as they occur.

By completing this application to become a participating provider with Delta Dental of North Carolina (DDNC) or any DDNC affiliate or a network administered by DDNC. I fully understand that any significant misstatement in, or omission from, my application to become a participating provider may constitute cause for denial of my application or the subsequent termination of my participating provider contract if my application is accepted. I understand and agree that this consent is irrevocable for any period during which I am a participating provider with DDNC. DDNC reserves the right to base acceptance into any individual network based on criteria established by DDNC.

I understand that my application may require DDNC 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 authorize release from liability all representatives of DDNC, including any agent of DDNC, my state licensing board, clinics, other institutions, professional societies, professional malpractice insurance carrier(s) and any staff, for their acts performed in good faith and without malice in connection with the gathering and exchange of information as consented above or to release information as required by State or Federal laws, rules, or regulations.

I understand and agree that I have the responsibility of producing adequate information for proper evaluation of my continued professional competence, ethics and other qualifications and for resolving any doubts about such qualifications. I further understand and agree that I have a continuing affirmative duty to immediately inform DDNC of any future restrictions or revocation of my professional license, any disciplinary action, suspension or voluntary/involuntary limitation, denial of my clinical or other privileges, or any other event which may adversely reflect upon my professional competence, ethics and other qualifications as a participating provider.

I understand that subject to proper confidentiality restrictions and authorizations, my dental records will be subject to inspection by DDNC for quality assurance and utilization review purposes.

Signature _____ **Date** _____

Name _____

(Please print or type)

Delta Dental of North Carolina'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.