Delta Dental of Minnesota

CREDENTIALING APPLICATION

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

Credentialing Application is complete when:

- ❑ The Credentialing Application has been signed and updated.
  (DDMN does NOT accept STAMPED SIGNATURES)
- ❑ Employment history in chronological order for the most recent 5 years.
  (Leave no gaps in chronology)
- ❑ Current Copies of the following have been attached:
  - ✓ Dental License (provide copies for EVERY state in which you are licensed)
  - ✓ DEA Registration for **EVERY STATE** the DDS is participating in (or documentation DEA is pending)
  - ✓ Board/Specialty Certificate (if applicable)
  - ✓ Professional Liability Insurance Declaration Page – showing minimum coverage of $1 million/$3 million, dentist's name, policy #, effective and expiration dates.
    - If expiration date is within weeks of this application, updated documentation must be submitted.
- ❑ W-9 Form or Taxpayer Identification Number Request
- ❑ Confidential Filed Fee Schedule **OR** note stating taking on clinics existing filed fee schedule

Please attach signed contracts for each network you wish to participate in as follows:

- ❑ Dentist Membership and Participation Agreement (Delta Dental Premier)
- ❑ Delta Dental PPO
- ❑ Senior Discount Program (addendum)
- ❑ State Dental Plan
- ❑ Medica
- ❑ CivicSmiles
- ❑ CivicSmiles Senior (addendum to CivicSmiles)

MAIL CREDENTIALING APPLICATION TO:
Delta Dental of Minnesota
500 Washington Avenue South
Minneapolis, MN 55415-1163
FAX: (651) 994-5130 or toll free (866) 286-8840

QUESTIONS? Call (651) 406-5900 x4170 or toll free (800) 328-1188 x4170

Notice of Applicant's Right

You may review or request the status of 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 Minnesota 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 of submitting 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 and Protection Data Bank.

Confidentiality Statement

Delta Dental of Minnesota (DDMN) 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.
DDMN strictly enforces the provisions designed to safeguard information and ensure confidentiality.

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

Name:	_____ Last First MI
Social Security Number:	___ ___ ___ - ___ ___ - ___ ___ ___ ___
Individual NPI:	___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___
Date of Birth:	___ ___ / ___ ___ / ___ ___ ___ ___
Gender:	☐ Male ☐ Female
Federal DEA:	Do you currently hold a Federal DEA registration? ☐ Yes (Submit copy) ☐ No **If Federal DEA is PENDING or issued in a <u>different</u> State other than the State you are intending to participate, please complete**: I Dr. _____ will not write prescriptions till I have received my current Federal DEA in the State of _____. Dr. _____ will be writing prescriptions on my behalf until my current Federal DEA has been received.
Languages Spoken Fluently:	_____

PRIMARY PRACTICE LOCATION - If more than one location please ATTACH a SEPARATE SHEET with the information below.
This address is used for directories and web searches

Primary Office:	_____ Group Name and Clinic Name (if different)
Street Address:	_____
City/State/Zip:	_____ County:_____
Office Phone Number:	(_____)_____ ER/After Hours Number: (_____)_____
Fax Number:	(_____)_____ Handicap Accessible ☐ YES ☐ NO
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.

CORRESPONDENCE INFORMATION: (If different from primary practice location) This address is used to send communications such as welcome letters and newsletters		**BILLING INFORMATION:** (if different from primary practice location) This address is for claim reimbursement	
Company Name:	_____	Company Name:	_____
Address:	_____	Address:	_____
	_____		_____
Office Manager/Contact:	_____	Office Manager/Contact:	_____

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 **showing institution name, grad yr, and specialty**)
☐ **American Board Certified *** (**ATTACH COPY** of certificate **from the American Board**)
*Date of Certification: _____ Expiration Date: _____

DISCLOSURE QUESTIONS

Please **complete the malpractice or board action addendum** if any "yes" answers to questions 1 through 10.

1. ☐ Yes ☐ No **Have you ever** had your **professional license, registration or DEA** terminated, stipulated, restricted, limited, conditioned, subjected to corrective action, 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 minor violations), 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.)
9. ☐ Yes ☐ No **Have you ever** had your Malpractice (Professional Liability) carrier refuse or cancel your coverage?
10. ☐ 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?

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 Minnesota 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 Minnesota (DDMN) or any DDMN affiliate or a network administered by DDMN. 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 DDMN. DDMN reserves the right to base acceptance into any individual network based on criteria established by DDMN.

I understand that my application may require DDMN 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 DDMN, including any agent of DDMN, 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 DDMN 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 DDMN for quality assurance and utilization review purposes.

Signature _____ **Date** _____

Name _____

(Please print or type)

Malpractice or Board Action

Please complete addendum **ONLY** if you answered "YES" to disclosure questions 1-9.
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: _____

_____

_____

_____

_____

EMPLOYMENT HISTORY: Chronological listing must include MONTH and YEAR for each entry of employment history for the most recent 5 years. List all armed service, public health, education, business or professional activities, sabbatical, etc. LEAVE NO GAPS IN CHRONOLOGY.

Please Note: You will be added to directories as participating for all locations you have indicated you are currently working at. Please provide the facility address, phone number, tax identification number and a W9 for each location.
Please list whether you are an owner, partner or associate for each location you currently work at.

Dates (Month & Year)	Facility and Address	Phone Number & TIN	Reason for Leaving:
From: ____ / ____ To: **Present**	Current Location		
From: ____ / ____ To: ____ / ____			
From: ____ / ____ To: ____ / ____			

PRIMARY ADMITTING FACILITY (List present hospital/surgical center privileges in chronological order beginning with the most recent.)

Primary Admitting Facility:	_____
Street Address:	_____
City/State/Zip:	_____

Delta Dental of Minnesota's selection process ensures 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.