

RE-CREDENTIALING APPLICATION

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.

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 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-Health Integrity Protection Data Bank.

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 (DDMN) 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 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.

DISCLOSURE QUESTIONS

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

1. Yes No Within the last five (5) years, has your **professional license, DEA or registration** been denied, terminated, relinquished, restricted, suspended or otherwise disciplined, including corrective action or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?
2. Yes No Within the last five (5) years, has your **participation, clinical privileges, employment or licensure** been denied, terminated, relinquished, restricted, suspended or otherwise disciplined, including corrective action by licensing board, health related agency or organization, or is there a review pending?
3. Yes No Are there any **charges pending or are you currently charged with** or have you ever been indicted or found guilty of a felony, misdemeanor (other than a minor traffic violation), or other offense involving fraud, misrepresentation, dishonesty or deceit or been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment?
4. Yes No Within the last five (5) years, has your Malpractice (Professional Liability) carrier refused or canceled your coverage or have you had any Malpractice (Professional Liability) claims or lawsuits brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? (This includes status of any pending claims previously reported.)
5. Yes No Are you currently using illegal drugs or 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?
6. Yes No Are all your practice locations **handicap accessible**?

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Signature _____ **Date** _____

Name _____
(please print or type)

Are you Board Certified (check box): **Yes** **No** * (attach certificate copy from **Specialty Board**)

- Date of Certification: _____ Expiration Date: _____

Malpractice Claims (s)

Date of Occurrence: _____ Settlement Amount: _____ Current Status: _____

Date Resolved _____ Name & Address of Insurance Carrier _____

Details of Allegations: _____

Board Action (s)

Date of Occurrence: _____ Date Resolved _____ Amount of Fine Paid: _____

Details of Action (conditions, limitations, etc.) Attach copy of Action:

Delta Dental of Minnesota's process for Re-Credentialing is 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.