<u>Checklist for Delta Dental Credentialing</u>

In addition to the credentialing application, **the following listed items must be submitted**. Please be sure that copies of these items are legible and clear.

Missing items will delay the application process and applications will be held until all items have been received.

- ✓ <u>DEA certificate</u>-please note that it must be issued to the applicant's name in the state they are requesting participation.
  If the dentist does not have a DEA a notice indicating the name and license number of another dentist who can prescribe for them is acceptable.

- **V** <u>State Dental License</u>

- **V** <u>Professional Liability Certificate</u>-please note that the applicant's name must be on the certificate and have a non-expired date. If the certificate is within 30 days of expiration a continuation will be requested.

- **V** <u>Diploma/Specialty Certificates</u>- if the applicant is a **ǎǇŜŏǐŀ-ƚǐǎű** (Prosthodontics, Oral Surgery, Endodontics, Orthodontics, Pedodontist) please supply a copy of the certificate or diploma from their educational institution.

- ✓ <u>Provider Authorization & Release Form</u>

- ✓ <u>Additional Information Form (Facility Profile)-</u>Form helps with the CMS and DDPA requirements regarding information that is listed on the website.

- ✓ <u>Fees</u>- the applicant will need to supply a Confidential Filed Fee (CFF) schedule with this application. OR provide the full name of an already existing & credentialed provider that we can use to copy the fees from.

- ✓ <u>Signed Participation Agreements</u>- contracts for all of the networks the applicant is wanting to participate in.

Delta Dental of Minnesota

PROVIDER AUTHORIZATION AND RELEASE

By completing this Minnesota Uniform Dental Initial Credentialing Application (the "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 misstatement in, or omission from, my Application 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, and that 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 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 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, any change in my malpractice insurance coverage (including changes in the insurance carrier or policy number) or any other event which may adversely reflect upon my professional competence, ethics and other qualifications as a participating provider. Additionally, I hereby certify that my office protocols for infection control are in compliance with current Centers for Disease Control and Occupational Safety and Health Administration guidelines.

Signature _____ **Date** _____

Name _____

(Please print or type)

Minnesota Uniform Dental Initial Credentialing Application

CREDENTIALING CONTACT INFORMATION (please provide contact information If you would like us to contact someone other than you (the provider) in the event that we have questions related to this credentialing application)

Name _____ **Phone Number** _____

Address _____ **Fax Number** _____

_____ **E-mail** _____

_____

Instructions

The initial credentialing application and attachments should be typed, legibly printed in black ink, or electronically generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Please mark all non-applicable sections with N/A.

Checklist (please complete)
Current copies of the following documents must be submitted with this application.

- ☐ Diploma (if educated outside of U.S. or Canada)
- ☐ Malpractice Litigation and Professional Complaints Form (if applicable)
- ☐ Malpractice liability insurance face sheet or certificate of insurance

In addition, please verify that you:

- ☐ Provide complete addresses wherever indicated, including past employment, and references
- ☐ Designate dates by month and year time frames
- ☐ Explain all gaps of greater than three months in chronology (Page 4)
- ☐ Answer all of the Disclosure Questions on Pages 6 and 7 and enclosed explanations for affirmative answers
- ☐ Sign and date the Attestation Signature and Date statement (Page 7)
- ☐ Sign and date the Authorization and Release
- ☐ Keep a copy of your completed application for your records

All Information Must Be Printed in Black Ink, Typed or Electronically Generated

.

This credentialing application is accepted by the following dental plans:

- **Delta Dental of MN**
- **HealthPartners**

Personal Data

Name: _____
Last First Middle Suffix Title

Maiden/Former/Other Name(s):_____ Gender: □ Male □ Female

Date of Birth:_____/_____/_____ Social Security Number: _____ NPI:_____

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language? □ Yes □ No

If yes, specify languages: _____

Primary or Pending Practice Location

Primary Practice Location/Clinic Name:_____

Address:_____
Street City/State/County Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number: _____ E-mail Address:_____

Type II (facility) NPI:_____

Start date at this location:_____ Specialty in which care will be provided:_____

Additional Practice Location(s) (If additional space is required, attach a separate sheet)

Other Practice Name:_____

Address:_____
Street City/State/County Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number (if different than primary): _____ E-mail Address:_____

Type II (facility) NPI (if different than primary):_____

Start date at this location:_____ Specialty in which care will be provided:_____

Other Practice Name:_____

Address:_____
Street City/State/County Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number (if different than primary): _____ E-mail Address:_____

Type II (facility) NPI (if different than primary):_____

Start date at this location:_____ Specialty in which care will be provided:_____

Other Practice Name:_____

Address:_____
Street City/State/County Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number (if different than primary): _____ E-mail Address:_____

Type II (facility) NPI (if different than primary):_____

Start date at this location:_____ Specialty in which care will be provided:_____

Dental School

(Month and year required)

From _____/_____/_____ Institution Name:_____

To _____/_____/_____ Degree Received: ☐ DMD ☐ DDS Other:_____

City:_____State:_____Country:_____

Phone Number: _____ Fax Number:_____

From _____/_____/_____ Institution Name:_____

To _____/_____/_____ Degree Received: ☐ DMD ☐ DDS Other:_____

City:_____State:_____Country:_____

Phone Number: _____ Fax Number:_____

Residency/Post-Graduate/ Training (If additional space is required, attach a separate sheet.)

(Month and year required)

From: _____/_____/_____ Institution Name:_____

To: _____/_____/_____ Type of Program/Specialty:_____

Completed Training: ☐ Yes ☐ No If no, expected completion date:_____

If yes, degree received:_____

☐ Certificate ☐ N/A ☐ Other, please explain_____

If not successfully completed, explain:_____

City:_____State:_____Country:_____

Residency/Post-Graduate/ Training (If additional space is required, attach a separate sheet.)

(Month and year required)

From: _____/_____/_____ Institution Name:_____

To: _____/_____/_____ Type of Program/Specialty:_____

Completed Training: ☐ Yes ☐ No If no, expected completion date:_____

If yes, degree received:_____

☐ Certificate ☐ N/A ☐ Other, please explain_____

If not successfully completed, explain:_____

City:_____State:_____Country:_____

Chronological Employment/Practice History (include Military Service) (Additional space is provided on the Chronological Employment/Practice History Addendum, page 9. You may make extra copies of page 9 or attach a separate sheet for additional employment.)

Chronological listing [month/year] of employment/practice history **for the most recent 10 years or from your post-graduate training if that is less than 10 years.** List all experience, including military service and public health, time out of dental practice in pursuit of other business or professional activities, sabbaticals, parenting, personal travel, personal crisis, etc. **LEAVE NO GAPS IN CHRONOLOGY**.

(Month and year required)

From: _____/_____/_____ Organization Name/Activity: _____

To: _____/_____/_____ Reason for Leaving:_____

City:_____State:_____Country:_____

Phone Number:_____

From: _____/_____/_____ Organization Name/Activity: _____

To: _____/_____/_____ Reason for Leaving:_____

City:_____State:_____Country:_____

Phone Number:_____

From: _____/_____/_____ Organization Name/Activity: _____

To: _____/_____/_____ Reason for Leaving:_____

City:_____State:_____Country:_____

Phone Number:_____

From: _____/_____/_____ Organization Name/Activity: _____

To: _____/_____/_____ Reason for Leaving:_____

City:_____State:_____Country:_____

Phone Number:_____

Explain gaps/interruptions of <u>greater than three (3) months</u> to practice of dental/professional practice (if additional space is required, attach a separate sheet):

From: _____/_____/_____ Explain : _____

To: _____/_____/_____ _____

From: _____/_____/_____ Explain : _____

To: _____/_____/_____ _____

Liability Insurance - Insurance Carrier for Primary and Pending Practice Location

☐ Attach a copy of professional liability insurance coverage (e.g., face sheet/verification of self-insurance) for **primary practice location** It must include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered.

☐ Certificate Pending

Licensure - List all past, current and pending professional licenses.

State	License Number	Date Issued	Expiration Date	License Status
_____	_____	_____/_____/_____	_____/_____/_____	☐ Active ☐ Inactive ☐ Pending
_____	_____	_____/_____/_____	_____/_____/_____	☐ Active ☐ Inactive ☐ Pending
_____	_____	_____/_____/_____	_____/_____/_____	☐ Active ☐ Inactive ☐ Pending

Drug Enforcement Administration Registration

☐ Not applicable to practice
☐ DEA certificate pending; date application submitted to DEA: ____ /____/____

DEA Number:_____ State:_____ Expiration Date: _____/_____/_____

NOTE: Address on DEA certificate must be in state where you will be practicing as applicable to this application

Specialty/Subspecialty Certification

☐ I do not hold specialty/subspecialty certification

Certifying Board	Specialty/Subspecialty	Date Certified	Date Recertified	Expiration Date	Cert. Pending
_____	_____	____/____/____	____/____/____	____/____/____	☐
_____	_____	____/____/____	____/____/____	____/____/____	☐

Primary Hospital Affiliation (pertinent to Primary or Pending Practice Location listed on page 2)

(Month and year required)

From: _____/_____/_____ Facility Name:_____

To: _____/_____/_____ City:_____State:_____

☐ Application Pending Admitting Privileges ☐ Yes ☐ No

Other Current Hospital Affiliations

(Month and year required)

From: _____/_____/_____ Facility Name:_____ If hospital changed name, list current name and address

To: _____/_____/_____ City:_____State:_____

☐ Application Pending Admitting Privileges ☐ Yes ☐ No

From: _____/_____/_____ Facility Name:_____ If hospital changed name, list current name and address

To: _____/_____/_____ City:_____State:_____

☐ Application Pending Admitting Privileges ☐ Yes ☐ No

From: _____/_____/_____ Facility Name:_____ If hospital changed name, list current name and address

To: _____/_____/_____ City:_____State:_____

☐ Application Pending Admitting Privileges ☐ Yes ☐ No

Disclosure Questions for Initial Credentialing

Please provide a complete explanation if any of the following questions are answered in the affirmative. Use a separate sheet to continue, if necessary.

1. ☐ Yes ☐ No Has your **professional license or registration** ever been 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?

2. ☐ Yes ☐ No Has your **professional license or registration** ever been investigated or is it currently being investigated and, if so, what were the results?

3. ☐ Yes ☐ No Has your **DEA registration** ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?

4. ☐ Yes ☐ No Has your **membership, participation, clinical privileges, or employment** ever been 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?

5. ☐ Yes ☐ No Have you ever voluntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?

6. ☐ Yes ☐ No Have you ever involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license or registration?

7. ☐ Yes ☐ No Has your **membership or fellowship** in any professional organization or your specialty **board certification** ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?

8. ☐ Yes ☐ No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever 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?**

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

10. ☐ 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, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense?

11. ☐ Yes ☐ No Have you ever been found liable, guilty or responsible for **sexual impropriety** or misconduct or sexual harassment \ with a patient, co-worker, or other?

12. ☐ Yes ☐ No Have you ever had any **professional liability claims or lawsuits** brought against you**,** including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? **If yes, please complete the enclosed Malpractice Litigation and Professional Complaints Addendum.** You may be asked for additional information by individual organizations.

13 ☐ Yes ☐ No Has your **professional liability carrier** ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?

14. ☐ Yes ☐ No Have you ever practiced within your profession without **professional liability insurance?**

15. ☐ Yes ☐ No Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in your area of practice without posing a health or safety risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

16. ☐ Yes ☐ No Does your use (or have you been told that your use) of alcohol or drugs affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice without posing a health risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

17. ☐ Yes ☐ No Are you currently using illegal drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice dentistry. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

Attestation Signature and Date

I hereby certify 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 complete, true and accurate while my application is being processed.

Signature _____ Date _____

Name _____
(please print or type)

Notice of Applicant's Rights

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 applicable state or federal laws. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to correct erroneous information submitted by another party. This includes information submitted by an outside source such as state license boards, malpractice insurance carriers, hospitals, and the National Practitioner Data Bank.

Malpractice Litigation and Professional Complaints Addendum

Confidential Information

If you answered yes to disclosure question #12 on Current Disclosure question page, please complete the following form. For each lawsuit or complaint, please furnish the following and attach a copy of the complaint including your response to the complaint and level of participation. It is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc.) of your response. You may choose to have your attorney complete this form. Please make additional copies of this form if needed.

Month/Year of incident: _____/_____ **Reported to the NPDB:** □ Yes □ No

Where incident occurred:

Facility Name: _____ **Address:** _____

City: _____ **State:** _____ **ZIP:** _____

Describe the nature of incident (Complaint, Allegation) - Do Not Include Patient Name or Identifiers

Provide a narrative description of your participation/level of care

Outcome of incident

CONCLUDED WITH NO PAYMENTS ONLY:

□ Dropped/Closed Date: _____/_____

□ Verdict for you Date: _____/_____

□ Dismissed with prejudice? Date: _____/_____

□ Dismissed without prejudice? Date: _____/_____

CONCLUDED WITH PAYMENTS ONLY:

□ Verdict for plaintiff Date: _____/_____ Amount: _____

□ Settled Date: _____/_____ Amount: _____

PENDING

□ Pending Date: _____/_____ (date of occurrence)

Represented by Legal Counsel for this claim/malpractice lawsuit? □ Yes □ No If yes, give the name and address of counsel.

Name: _____

Address: _____

Phone Number: _____

Insurance company or employer that provided coverage for this claim:

Name: _____

Address: _____

Phone Number: _____ Policy Number: _____

Signature _____ **Date** _____

Print Name _____ **Phone Number** _____

Chronological Employment/Practice History Addendum

(Please make as many extra copies as necessary)

(This is an extra copy for your use if needed)

(Month and year required)

From: _____/_____/_____ Organization Name/Activity: _____

To: _____/_____/_____ Reason for Leaving:_____

City:_____State:_____County:_____

Phone Number:_____

From: _____/_____/_____ Organization Name/Activity: _____

To: _____/_____/_____ Reason for Leaving:_____

City:_____State:_____County:_____

Phone Number:_____

From: _____/_____/_____ Organization Name/Activity: _____

To: _____/_____/_____ Reason for Leaving:_____

City:_____State:_____County:_____

Phone Number:_____

From: _____/_____/_____ Organization Name/Activity: _____

To: _____/_____/_____ Reason for Leaving:_____

City:_____State:_____County:_____

Phone Number:_____

DELTA DENTAL®

Delta Dental of Minnesota

Additional Information Required for Delta Dental's Online Find a Dentist

Name	Last First MI
Languages Spoken	
Clinic Hours for Primary Location	Please enter start and end times (i.e. 8:00-4:30)
	Mon: Fri:
	Tues: Sat:
	Wed: Sun:
	Thurs:
Is the Primary Clinic Accessible by Public Transportation?	☐ Yes ☐ No
Is the Primary Clinic Handicap Accessible?	☐ Yes ☐ No
Second Clinic Name (if applicable)	
Clinic Hours for Second Location (if applicable)	Please enter start and end times (i.e. 8:00-4:30)
	Mon: Fri:
	Tues: Sat:
	Wed: Sun:
	Thurs:
Is the Secondary Clinic Location Accessible by Public Transportation?	☐ Yes ☐ No
Is the Secondary Clinic Handicap Accessible?	☐ Yes ☐ No
Do You Treat Children With Disabilities?	☐ Yes ☐ No

Over to Continue

Additional Information Required for Delta Dental's Online Find a Dentist, Page 2

Do You Treat Adults With Disabilities?	☐ Yes ☐ No
Are You Accepting New Patients All Networks?	☐ Yes ☐ No (If no, see next section)

If You Are Not Accepting Patients in All Networks, Please Indicate Which Network(s) You Are Accepting New Patients

	Accepting New Patients?
PPO	☐ Yes ☐ No
Premier	☐ Yes ☐ No
MN Select Dental	☐ Yes ☐ No
Delta Dental Medicare Advantage	☐ Yes ☐ No
ND Premier (CHIPS)	☐ Yes ☐ No
State Dental Plan	☐ Yes ☐ No

Have you opted out of Medicare? ☐ Yes ☐ No