Texas Dental Credentialing Application

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Provider Information

First Name:	MI:	Last Name:	Suffix (Jr., Sr., etc.):	□ Male □ Female
Other Name(s) Used/Name as Appears on Dental Degree:		DOB (MM/DD/YY): ____/____/____	**Specialty:** □ Dental Assistant □ Dental Hygienist □ Denturist □ Doctor of Dental Surgery □ Doctor of Dentistry □ Dental Anesthesiology	□ Endodontic Dentist □ Oral Pathology □ Oral Radiology □ Orthodontic Dentist □ Pediatric Dentist □ Periodontic Dentist □ Prosthodontic Dentist
SSN: - -	NPI-Type1:	□ Owner □ Assoc. □ Employee □ MD □ DDS □ DMD		
Email	Medicare Number			

Licensing Information *including current license(s) and history of licensure in all jurisdictions.* Please attach current copy copies with application.

State License Number:	State:	Effective Date:____/_____/_____	Expiration Date:____/_____/_____
State License Number:	State:	Effective Date:____/_____/_____	Expiration Date:____/_____/_____
DEA Number: DEA Release:	State:	Expiration Date:____/_____/_____	□ Not Applicable
CDS Number:	State:	Expiration Date:____/_____/_____	□ Not Applicable

Refer to emergency room? □ Yes □ No

Education/Training

Dental School Name:			Degree:
Graduation Mo/Yr.:	Attended From _____/_____ To _____/_____		
Address:	City:	State:	County:
Residency/Specialty Training Institution Name:		Program/Training Type:	
Graduation Mo/Yr.:	Attended From _____/_____ To _____/_____		
Address:		City:	State:
Board Certified: Yes No	Certifying Board Name:	Certification Date:	

Specialty:

Dental Training Outside US:

Are you an American board-certified diplomat? □ Yes □ No

Work History Include work history for the past 10 years. Beginning with the most recent.

Employer	Address (City, State)	Month/Year Started	Month/Year Ended
		_____/_____	_____/_____
		_____/_____	_____/_____
		_____/_____	_____/_____
		_____/_____	_____/_____

Explain any gap in work history greater than 6 months.

Professional Liability Insurance Required: attach a current copy of your malpractice insurance declaration page.

Professional Liability Insurance Carrier			Policy No.
Policy Effective Date (MM/DD/YY): ____/____/____	Policy Expiration Date (MM/DD/YY): ____/____/____	Occurrence Limit (per claim):	Aggregate Limit:

General Liability Insurance Please attach a current copy of your malpractice insurance declaration page.

General Liability Insurance Carrier			Policy No.
Policy Effective Date (MM/DD/YY): ____/____/____	Policy Expiration Date (MM/DD/YY): ____/____/____	Occurrence Limit (per claim):	Aggregate Limit:

Hospital Affiliations If not applicable, check here

Hospital Name	Address (City, State)	Privileges	Affiliation End date
			_____/_____

Practice Information **Please note:** Providers may only have four locations listed on provider directory portal.

Attach list of additional locations as applicable.

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Primary Practice Name:			Start Date (MM/DD/YY): _____/_____/_____
Practice Address:	City:	State:	County:
Business URL:			
Practice Phone No.: ( )	Practice Fax No.: ( )	Tax ID (Please submit W-9)	NPI No. (Type 2/Organization) or Sub-part:
Is Correspondence Address (if different from primary):		**Practice Type** □ Clinic □ School □ Hospital □ Academic Dental Center □ Multi Specialty Group □ Single Specialty Group	□ County □ Indian Health Services □ Mobile Unit □ FQHC □ RHC □ CHC □ Other:
Billing Address (if different from primary):			
Credentialing Contact:	Email Address:	Phone No.: ( )	

Practice hours	Sunday	Monday	Tuesday	Wedensday	Thursday	Friday	Saturday
Provider hours at Practice	Sunday	Monday	Tuesday	Wedensday	Thursday	Friday	Saturday

Publish on Directory □ Yes □ No	Publish on Web Portal □ Yes □ No	Are translation services available? □ Yes □ No
Have your staff completed cultural competency training? □ Yes □ No	Does your office provide access to a skilled medical interpreter? □ Yes □ No	
After Hours Coverage		

Special Needs Patients Do you accept special needs patients? □ Yes □ No

If yes, check all that apply:

□ ADHD □ AIDS □ Child □ Cognitive disability □ Development disabilities	□ End stage renal disorder □ Learning disabled and learning problems □ Paralysis □ Seizure disorders □ Adult □ Autism	□ Chronic illness □ Cultural competency training □ Difficulty communicating □ Hearing impaired □ Mobility limitations	□ Physical disability □ Serious mental illness □ Adult and child □ Behavioral disorders □ Co-existing disorders □ Deafness □ Duals demonstration	□ HIV □ Other □ Sedation services for members with complex medical or behavioral conditions □ Visually impaired

Age range of special needs patients Age from_____ Age to_____	Is your office on or near a public transportation line? □ Yes □ No	Is your office handicap accessible? □ Yes □ No	Handicap Parking Available? □ Yes □ No
Are you able to treat wheelchair confined patients? □ Yes □ No	Accepts new patients □ Yes □ No	Age of patients: from_____ to_____	

Second Practice Address

Second Practice Name:			Start Date (MM/DD/YY): _____/_____/_____
Second Practice Address:	City:	State:	County:
Business URL:			
Practice Phone No.: ( )	Practice Fax No.: ( )	Tax ID (Please submit W-9)	NPI No. (Type 2/Organization) or Sub-part:
Is Correspondence Address (if different from primary):		Practice Type □ Clinic □ School □ Hospital □ Academic Dental Center □ Multi Specialty Group □ Single Specialty Group	□ County □ Indian Health Services □ Mobile Unit □ FQHC □ RHC □ CHC □ Other:
Billing Address (if different from primary):			
Credentialing Contact:	Email Address:	Phone No.: ( )	

Practice hours	Sunday	Monday	Tuesday	Wedensday	Thursday	Friday	Saturday
Provider hours at Practice	Sunday	Monday	Tuesday	Wedensday	Thursday	Friday	Saturday

Publish on Directory □ Yes □ No	Publish on Web Portal □ Yes □ No	Are translation services available? □ Yes □ No
Have your staff completed cultural competency training? □ Yes □ No	Does your office provide access to a skilled medical interpreter? □ Yes □ No	

Special Needs Patients Do you accept special needs patients? □ Yes □ No

If yes, check all that apply:

□ ADHD □ AIDS □ Child □ Cognitive disability □ Development disabilities	□ End stage renal disorder □ Learning disabled and learning problems □ Paralysis □ Seizure disorders □ Adult □ Autism	□ Chronic illness □ Cultural competency training □ Difficulty communicating □ Hearing impaired □ Mobility limitations	□ Physical disability □ Serious mental illness □ Adult and child □ Behavioral disorders □ Co-existing disorders □ Deafness □ Duals demonstration	□ HIV □ Other □ Sedation services for members with complex medical or behavioral conditions □ Visually impaired

Age range of special needs patients Age from_____ Age to_____	Is your office on or near a public transportation line? □ Yes □ No	Is your office handicap accessible? □ Yes □ No	Handicap Parking Available? □ Yes □ No
Are you able to treat wheelchair confined patients? □ Yes □ No	Accepts new patients □ Yes □ No	Age of patients: from_____ to_____	

Professional Questions and Attestation Release (Not for Use for Employment Purposes)

1.	In the last five (5) years, have you had any gaps greater than six (6) months, where you did not work as a practitioner in this current discipline? If "YES," please explain the reason(s) for any gap(s) on a separate page.	□ Yes	□ No
2.	Have there ever been any actions against or investigations relating to your professional license(s) in any jurisdiction?	□ Yes	□ No
3.	Have you ever voluntarily or involuntarily surrendered your license?	□ Yes	□ No
4.	Have you ever been named in any malpractice action?	□ Yes	□ No
5.	Does your current liability malpractice insurance coverage exclude any specific procedures?	□ Yes	□ No
6.	Have you been without malpractice insurance coverage in the past five consecutive years? (For healthcare Practitioners in the Commonwealth of Massachusetts: Have you been without malpractice insurance coverage in the past ten consecutive years?)	□ Yes	□ No
7.	Has your professional liability insurance coverage ever been denied, suspended, restricted, limited, modified, canceled or not renewed by the action of any insurance company?	□ Yes	□ No
8.	Have you ever been convicted of a felony, including, but not limited to, fraud, narcotics, or crimes involving children? (Misdemeanors do not need to be reported.) This statement is being answered under the penalty of perjury, subject to applicable Federal punishment for perjury. If yes, please include the disposition of the arrest or charge and explain all such occurrences in an attachment.	□ Yes	□ No
9.	Have you ever been named as a defendant in any past or pending criminal proceedings including misdemeanors (excluding traffic violations)?	□ Yes	□ No
10.	Are you prevented from performing any procedures within the scope of privileges and duties as a healthcare provider?	□ Yes	□ No
11.	Have you ever voluntarily or involuntarily surrendered membership in a professional organization/association?	□ Yes	□ No
12.	Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*	□ Yes	□ No
13.	Has there ever been any disciplinary action, suspension, probation, formal reprimand or request to voluntarily or involuntarily resign during your education, internship, residency, fellowship, preceptorship, or additional applicable training?	□ Yes	□ No
14.	Has there ever been any action against or investigation relating to your board certification (e.g. medical professional board / society) or have you voluntarily or involuntarily surrendered any board certifications?	□ Yes	□ No
15.	Has an adverse action been filed against you or have you received any disciplinary procedures regarding your participation in any private, state, or federal insurance program including Office of Personnel Management, Medicare, Medicaid or TRICARE?	□ Yes	□ No
16.	Is there any physical, mental, or substance abuse problems that would prevent you from being able to completely perform essential job-related functions, without risk to patient safety or health, with or without reasonable accommodation?	□ Yes	□ No
17.	Are you currently using any illegal substances or are you chemically dependent on alcohol, drugs, or illegal substances?	□ Yes	□ No

If you answered "yes" to any of the above questions, please explain, in detail, on the Affirmative Answer Explanation(s) page.

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Affirmative Answer Explanation(s)
_____Question Number
_____Question Number
_____Question Number _____Question Number

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Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as "Entity"), and any of Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand my application for Participation with the Entity is not an application for employment and that acceptance of my application will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agent(s); and the Entity's designated professional credentials verification organization (collectively "Agents"), to investigate information, which includes oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release any and all information requested in furtherance of the credentialing process, including, but not limited to: my history of claims that have been made and/or are currently pending against me; and, any coverage details, including declaration sheet(s). I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to conclusion of any disciplinary proceedings or prior to commencement of formal charges, but after I have knowledge that formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

_____

Signature

_____

Name (Printed)

_____

Date Signed

Required:
This Application is authorized for use by the following dental plans:

___ MCNA
___ DentaQuest
___ UHC Dental

**** Please review list of required attachments on the next page**

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Required Attachments:

- Malpractice Insurance – CURRENT Certificate of Insurance Attached
  ATTENTION: If your current Malpractice Insurance is EXPIRING in the next 30 days or less - NEW copy of Malpractice Insurance Attached
- Additional Location Page Attached
- Additional Licensure Information Attached
- Attach all applicable Sedation/ Anesthesia Permits and Licenses
- Disclosure Statement if applicable

Credentialing Application

Certification, Statements, and Signature

I hereby acknowledge that the information provided in this application is material to the determination by **DentaQuest** whether or not to execute an agreement with me. I hereby represent and warrant that all information provided herein is true, correct and complete to the best of my knowledge, and I agree to notify **DentaQuest** in the event an error is discovered or when new events occur which alter the validity of any response herein. I hereby authorize **DentaQuest** to consult with individuals or institutions with which I have been associated and with others, including but not limited to past and present malpractice carriers, educational institutions, and state licensing boards, who may have information bearing on my professional competence, character and ethical qualifications and authorize the release of any such written or oral verification as needed by DentaQuest. I hereby release from liability for any such entity, institution, or organization that provides information as part of the application process.

I certify that:

* All parties of material interest have been identified and include no persons or entities with a potential for profit from self-referral,
* All services are provided by and under the "on Premise" supervision of a licensed dentist,
* The above information is complete, correct and true to the best of my knowledge,
* My malpractice information is current at the time of application and the limits are at or exceed the minimum amounts required by the Plan and DentaQuest.

Individual Provider Participation Attestation

Attestation to confirm that you have agreed to become a Participating Provider/Provider Dentist in the DentaQuest provider network, by means of your or your office's Provider Agreement with DentaQuest, to render services to Members pursuant to the Agreement with DentaQuest.

Power of Attorney

The undersigned does hereby constitute and appoint each owner, member and partner of the entity set forth in the space designated for "Entity Name" on Page 1 of this document ("Entity"), its true and lawful attorney-in-fact, in undersigned's name, place, and stead, to execute, acknowledge, sign and deliver any and all contracts, documents, and writings on undersigned's behalf in connection with arrangements with DentaQuest for the provision of dental services. And the undersigned grants said agent full power and authority to do, take, and perform all and every act and thing whatsoever requisite, proper, or necessary to be done, in the exercise of any of the rights and powers herein granted, as fully to all intents and purposes as undersigned might or could do if personally present, with full power of substitution or revocation, hereby ratifying and confirming all that said agent, or his/her/its substitute or substitutes, shall lawfully do or cause to be done by virtue of this power of attorney and the rights and powers herein granted.

Signature	Printed Name	Date

All applications are subject to review and approval by DENTAQUEST.

All information contained in a credentialing file will be held in strict confidence and available for review by only duly authorized employees of DentaQuest, the Plan, and/or third party review organizations (i.e. NCQA, etc.). Practitioner has the right to obtain a copy of their credentialing file by submitting a written, signed request to the Supervisor of Credentialing at the corporate headquarters for DentaQuest. Any corrections, additions, or clarifications to these files must be submitted in writing to the Supervisor of Credentialing within 30 days of the original submission. This information will be added to the provider application and considered in the credentialing decision. The practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application via phone, fax, or mail. If the Credentialing Committee recommends the acceptance of an application with restrictions, denial of an application, or discipline or termination of a practitioner, written notification will be issued within 30 days of that decision. The practitioner then has 30 days from the date of the notice to submit a written appeal of that decision. Appeals should be addressed to the Credentialing Committee, sent to DentaQuest's corporate address.

In the event that a dentist's application for participation is rejected or limited for reasons pertaining to the applicant's professional conduct or competence, DentaQuest is required to submit a report to the Plan. DentaQuest will submit a report to the National Practitioner Data Bank and the state licensing board as required by law.