



DentaQuest Credentialing

Required documents:

- DentaQuest Provider Service Agreement and W-9 (one per entity)
- Enclosed Provider Credentialing application (one per provider) or you may submit a **CAQH** application

What is CAQH?

The CAQH (Council for Affordable Quality Healthcare) offers a single credentialing application and an online data base that contains information necessary for insurance companies to credential a provider. This allows providers to submit and maintain their credentialing information at one location rather than filing with many organizations. There is no cost to file an application with CAQH and it can be completed online.

How do I submit my **CAQH** application?

Option 1 – I already have an application on file with CAQH

- **You must give CAQH authorization to release your information to DentaQuest**
- Fill out the chart below with your CAQH ID and fax to 262.241.7401
- OR -
- Fax CAQH application to: 262.241.7401

Option 2 – I want to complete on online CAQH application

- Complete and fax back the information in the below chart to 262.241.7401 (You do not need to fill-in the CAQH ID yet).
- Once DentaQuest has this information, CAQH will send you a Welcome packet with a CAQH ID. You may then complete the online CAQH application by logging onto <https://proview.caqh.org/PR/Registration> using your CAQH ID.

Required Fields	Provider 1	Provider 2	Provider 3
Full Provider Name			
Provider Type (DDS, DMD)			
License Number & Specialty			
Individual (Type I) NPI			
Date of Birth			
Mailing Address			
Phone			
Fax			
Email			
CAQH ID			

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.

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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.

Credentialing Application

Questionnaire

Please answer yes/no for each question. **Please Note:** Your responses must reflect your **ENTIRE** professional career.

DentaQuest uses the National Practitioner Database (NPDB) to verify any adverse licensure, malpractice history, hospital privileges and professional society actions against physicians and dentists related to quality of care. To obtain a copy of your NPDB report, **please perform a Self-Query** by visiting <https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp>.

If any adverse response(s) appear on your NPDB report, please answer this question with a “Yes” response and provide a written explanation.

Yes No

1. Has your Professional License been limited, suspended, denied, revoked, restricted, subject to probationary conditions, or have proceedings been instituted against you?		
2. Have you allowed your Professional License to expire in a state in which you no longer practice? Please list the states: _____		
3. Other than allowing a license to expire because you no longer practice in a state, have you voluntarily relinquished, reduced, restricted, or otherwise limited your Professional License in any jurisdiction?		
4. Have you been reprimanded or disciplined by any State or Commonwealth Department of Regulation and Licensure or any Professional Examining Board?		
5. Has your participation for receiving payment under the Medical Assistance, Medicaid, or Medicare program been suspended or limited or have you voluntarily terminated your participation?		
6. Has your participation with a managed care organization, other health care organization, or hospital privileges been suspended, limited, or terminated?		
7. Have you had a judgment made against you for alleged malpractice, negligence, or related matters? Are any cases pending?		
8. Have you had any judgments made against you in a professional liability case or has your liability insurer placed any conditions or restrictions on your coverage or ability to attain coverage?		
9. Have any litigation settlements been made on your behalf?		
10. Are you currently using illegal drugs?		
11. Are you, or have you been, under treatment for the use of narcotics, barbituates, alcohol, or other drugs?		
12. Do you presently have any physical or mental conditions that would adversely affect your ability to provide high quality professional services? Are there any accommodations that need to be considered? Please list accommodations in the pop up box.		
13. Has your Drug Enforcement Agency (DEA) registration been denied, revoked, suspended, or not renewed?		
14. Do you currently have an active DEA in the state(s) in which you practice? If not: <input type="checkbox"/> I refer my patients to their Primary Care Physician or Urgent Care/Emergency Room <input type="checkbox"/> _____ will write any prescriptions needed for my patients Prescribing Provider’s DEA Number _____		
15. Do you currently have an active CDS in the state(s) in which you practice? If not: <input type="checkbox"/> I refer my patients to their Primary Care Physician or Urgent Care/Emergency Room <input type="checkbox"/> _____ will write any prescriptions needed for my patients Prescribing Provider’s CDS Number _____		
16. Have you been convicted of any criminal offenses, pending or otherwise, other than a minor traffic violation?		
17. Do you use any form of protective stabilization without having completed a residency program, a graduate program, or a Continuing Medical Education (CME) certified course in protective stabilization?		

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Yes No

18. (New Jersey providers only required to complete this question) Documentation for my patients is compliant with the record keeping requirements found in the DentaQuest Office Reference Manual?		
19. (New Jersey providers only required to complete this question) Do you treat patients in a Nursing Home or Long Term Care facility? If yes have you performed pre-employment criminal history check and/ or background investigation on all staff members? Yes <input type="checkbox"/> No <input type="checkbox"/>		
20. (New Jersey providers only are required to complete this question) Are accommodations made for the patient’s cultural and linguistic needs and are they noted in the patient’s dental record?		
21. (Florida Medicaid Providers only) I attest and affirm that this office maintains a ratio of one FTE per 1,500 active patients and 500 additional active patients for each FTE licensed dental hygienist up to a maximum of two hygienists per FTE dentist. <ul style="list-style-type: none"> • The active patient load is a complete count of all the office’s active patients for all lines of business and plans (including Medicaid, Medicare and commercial) • An active patient is defines by AHCA as any patient who has been seen by the office two times in the last year For example, if a patient was seen only one time in the last year they would not be considered and active patient. • FTE stands for full time equivalent. 		
22. (New Mexico providers only are required to complete this question) Are you enrolled with the State of New Mexico?		