LIBERTY DENTAL PLAN

Provider Credentialing Application

(Complete one application per Provider) (* Required Fields)

Credentialing Information:

Owner: ☐ **Associate:** ☐

***PROVIDER NAME:** _____ ☐DDS ☐ DMD ☐Other (specify) _____

***DATE OF BIRTH:** ___/___/___ Gender: ☐ Male ☐ Female

Owning Dentist Name: _____

***PRACTICE NAME (DBA):** _____

***PRIMARY PRACTICE ADDRESS:** _____

***CITY, STATE, ZIP:** _____ County: _____

***OFFICE PHONE #:** ( ) - **EMERGENCY PHONE #:** ( ) - ***FAX #:** ( ) -

Email Address: _____

***TAX IDENTIFICATION #:** _____ ***SOCIAL SECURITY #:** - -

Medicaid Provider? ☐YES ☐NO (If Yes, ALL NPI #'s must be registered with appropriate State Agency)

Provider NPI # (Type 1) _____ Facility NPI # (Type 2) _____

Enter the following if Applicable

Provider State Medicaid Rendering #: _____ Provider State Medicaid Billing #: _____

Education Information:

***Dental School Attended**: _____ ***Year Graduated**: _____

***City**: _____ State: _____ Country _____

Specialty School Attended: _____ Year Graduated: _____

City: _____ State: _____ Country _____

☐General ☐Specialist (specify): _____ ***Board Certified**: ☐Yes ☐No

***Do you have Hospital Privileges?** ☐Yes ☐No Do you administer Sedation? ☐Yes ☐No

Hospital Name: _____ City/State/Zip: _____ Phone: _____

*Licensure & Professional Liability Information:

***Please attach a copy of your current:** 1) malpractice insurance 2) dental license 3) DEA*

***License #:** _____ State: _____ **EXPIRATION DATE**: _____

***DEA #:** _____ **EXPIRATION DATE**: _____

***Malpractice Insurance Carrier:** _____ **EXPIRATION DATE**: _____

***Policy #:** _____ ***Amount of Liability** _____

Effective Date: Phone #:

*5 Year Work History:

Please supply a 5 Year Work History including your **current location** and any GAPS in employment of 6 months or longer. Dates must show MONTH and YEAR.

PRACTICE NAME: (Current Location)

Address:

City: **State:** **Zip:**

From Dates: Month / Year **to** **Current**

PRACTICE NAME:

Address:

City: **State:** **Zip:**

From Dates: Month / Year **to** Month / Year

PRACTICE NAME:

Address:

City: **State:** **Zip:**

From Dates: Month / Year **to** Month / Year

PRACTICE NAME:

Address:

City: **State:** **Zip:**

From Dates: Month / Year **to** Month / Year

PRACTICE NAME:

Address:

City: **State:** **Zip:**

From Dates: Month / Year **to** Month / Year

Alternative Languages Spoken: _____

LIBERTY Dental Plan Questions:

1. Do you provide all services as outlined in the schedule of benefits?

   ☐ Yes ☐ No If No, please explain: _____

2. Do you participate in any other DHMO or PPO Programs (please list) _____

3. Would you be interested in serving on a Peer Review Panel or Quality Assurance Committee? ☐ Yes ☐ No

*Professional Questions and Attestation: (All questions must be answered)

For each "YES" response please include a detailed explanation with this form.
If a question is "Not Applicable," please mark "NO" for each response.

1. In the past five (5) years, have you had any gaps of six (6) months or greater, 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. Please mark "NO," if any gaps occur education and employment.
   ☐ **Yes** ☐ **No**

2. Has your license(s) to practice in any jurisdiction(s), whether completed or still pending, ever been denied, limited, suspended, revoked, not renewed; or have you ever been placed under probation, subject to disciplinary action or have you voluntarily relinquished any item in anticipation of any of these actions?
   ☐ **Yes** ☐ **No**

3. Has your professional liability insurance ever been denied, suspended, canceled, or subjected to any disciplinary action?
   ☐ **Yes** ☐ **No**

4. Have any of your DEA or State Drug Certificate registrations ever been denied, suspended, canceled, or subjected to any disciplinary action?
   ☐ **Yes** ☐ **No**

5. Has your status as a provider, or membership with any professional organization, ever been denied, suspended, discipline, canceled, sanctioned,; or are you currently under investigation by any municipal, state, federal or any other government agency, HMO, PPO or other prepaid health plan? (e.g. Medicare, Medi-Cal, Medicaid).
   ☐ **Yes** ☐ **No**

6. Are your privileges or memberships at any hospital or institution (Military Service) currently under investigation or have they ever been denied, suspended, reduced, disciplined, or not renewed?
   ☐ **Yes** ☐ **No**

7. Are you prevented from performing any procedures within the scope of privileges and duties as a healthcare provider?
   ☐ **Yes** ☐ **No**

8. Do you currently, or did you in the last five years, engage in the unlawful use of drugs, including the improper use of prescription drugs?
   ☐ **Yes** ☐ **No**

9. Do you have any felony or misdemeanor charges pending against you, other than a traffic violation, or have you ever been convicted or pleased "nolo contendere" to a felony?
   ☐ **Yes** ☐ **No**

10. Have you been involved, within the last ten (10) years, or are you currently involved in ANY claims/lawsuits, settlements, or judgments (other than divorce or custody)? If yes, please provide detailed information on a separate sheet of paper including: docket # of the case, location of the court, the names of the party plaintiff(s) and defendant(s), description and date(s) of the incident(s), your involvement, current disposition, and the amount of settlement.
    ☐ **Yes** ☐ **No**

11. Are you currently practicing WITHOUT, or with an EXPIRED, Professional Liability/Malpractice Insurance?
    ☐ **Yes** ☐ **No**

12. Have you ever been reported to the National Practitioner's Data Base?
    ☐ **Yes** ☐ **No**

I hereby make formal application for provider panel membership with **LIBERTY Dental Plan.**

***DOCTOR'S SIGNATURE:** _____ ***DATE:** _____
(No Signature Stamps)

***PRINT NAME:** _____ ***LICENSE #:** _____ ***STATE:** _____

Information Release / Acknowledgments:

I authorize **VerifPoint/CreDENTALs, LIBERTY Dental Plan's contracted CVO**, to consult with professional liability carriers, and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics, and other qualifications.

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("Credentialing Information") by and between LIBERTY Dental Plan and other Healthcare Organizations (e.g. hospital medical staffs, medical groups, independent practice associations (IPA's), health plans, health maintenance organizations (HMO's), preferred provider organizations (PPO's), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any re-credentialing application regarding my professional training, experience, character, conduct and judgment, ethics and records, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patients' records and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare provides. I hereby release all persons and entities, including LIBERTY Dental Plan and its agent(s), engaged in quality assessment, peer review and credentialing on behalf of LIBERTY Dental Plan, and all persons and entities providing credentialing information to such representatives of LIBERTY Dental Plan, from any liability they might incur for thei acts and/or communications in connection with evaluation of my qualifications for participation with LIBERTY Dental Plan, to the extent that those4 acts and/or communications are protected by state and federal law.

I, the undersigned, hereby certify that the information requested by VerifPoint/CreDENTALs is truthful, correct and complete in all respects, and I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating provider with the affiliated organization contracted with the VerifPoint/CreDENTALs. The undersigned hereby agrees to notify VerifPoint/CreDENTALs of any changes in the above information.

***DOCTOR'S SIGNATURE:** _____ ***DATE:** _____

(No Signature Stamps)

Print Name Here: _____

ADDENDUM TO LIBERTY DENTAL PLAN PARTICIPATING PROVIDER APPLICATION

Notice to Providers of Credentialing Rights

I. Right of Review

As an applicant for credentialing/re-credentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Dental Boards, and the National Practitioner Data Bank. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure.

You may request to review such information at any time by sending a written request via fax or letter to the Credentialing Department, P.O. Box 26110 Santa Ana, CA 92799-6110, fax number 800-268-0154. Following receipt of your request, you will be contacted by the Credentialing Department, within five (5) business days.

II. Notification of Discrepancy

You will be notified in writing, by fax or letter, when information obtained during primary source verification differs from information submitted on the application.

III. Correction of Erroneous Information

If you believe that erroneous information has been supplied to LIBERTY you may correct such information by submitting written notification to the Credentialing Department at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to the address above within fifteen (15) business days.

Upon receipt of your notification, LIBERTY will re-verify the primary source information. If the primary source information has changed, an immediate correction will be made to your credentialing file. If the primary source information remains inconsistent you will be advised of through a letter, fax, or phone call. If proof of correction is required then you must notify the credentialing department within ten (10) business days.