Liberty Dental Plan, Inc.

Associate Provider Application for Participation

Site Information

Owning Dentist ____

Associate
Dentists Name____

Practice Name (if different)____

Practice Address ____

City, State, Zip____

Mailing Address (if different)____

City, State, Zip____

County______________________ Tax Identification #________________________

Medi-Cal Billing ID # ____________________________ Medi-Cal Provider ID # __________________

Office Phone____________________Emergency Phone___________________Fax__________________

Number of Dentists______________ Number of Operatories______________

Alternative Languages Spoken____

Office Hours

Monday________Tuesday_________Wednesday________Thursday_________Friday________

Saturday_________ Sunday_________

Education Information

U.S. Dental School Attended___________________________Year Graduated______________

[ ] General [ ] Specialist, Specialty__________________Are you Board Eligible [ ]Yes [ ]No

(Please turn page)

Licensure & Professional Liability Information

License #_________________State_____________Expiration Date_________________

Malpractice Insurance Carrier_________________________Phone__________________

Policy Number___________________Amount of Liability_________________________

Effective Date___________Expiration Date___________

Confidential Information

Has your license to practice dentistry ever been revoked, suspended or on probation? [ ]Yes [ ]No

Has your DEA license ever been revoked, suspended or on probation? [ ]Yes [ ]No

Have you ever been indicted for, or convicted of a felony charge? [ ]Yes [ ]No

Have you ever been reported to the National Practitioners Data Bank? [ ]Yes [ ]No

Is anyone in your practice currently involved in any malpractice litigation? [ ]Yes [ ]No

Have you ever been subject to sanctions by Medicare, Medicaid, or any other government agency?
[ ]Yes [ ]No

Have any government agencies or insurance companies ever filed fraud charges against you?
[ ]Yes [ ]No

Do you currently have any chemical dependency or substance abuse problems that may impair your ability to practice? [ ]Yes [ ]No

Do you currently have any physical or mental health problems that may impair your ability to practice?
[ ]Yes [ ]No

Do you participate in any other DHMO or PPO programs (please list)___________________________

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Do you provide all services as outlined in the schedule of benefits? [ ]Yes [ ]No If no explain_____

____

Would you be interested in serving on a Peer Review Panel or Quality Assurance Committee?
[ ]Yes [ ]No

I hereby make formal application for provider panel membership with LDP.

Doctor's Signature:____Date:_____________________