LIBERTY DENTAL PLAN
Provider Application for Participation

Please complete one application per dentist, per location **Dentist Owner:** ____
Associate: ____

Site Information

Dentists Name__________________________ ☐ DDS ☐ DMD ☐Other (specify)_____________

Date of Birth_____________ Gender ☐ Male ☐ Female

Practice Name (if different)____

Practice Address ____

City, State, Zip____

Mailing Address (if different):____

City, State, Zip____ County ________________

NPI______________________ Medicaid Provider? ☐YES ☐NO State Billing #_____________________

Tax Identification #:________________________ Social Security #:__________________________

Office Phone (___)________________Emergency Phone (___)_____________Fax (___) ___________

Legal entity (check one) ☐ Corporation ☐ Partnership ☐ Sole proprietor

Alternative Languages Spoken____

Office Hours:

Monday___to_____Tuesday____to_____Wednesday___to_____Thursday____to_____Friday___to_____

Saturday___to______ Sunday___to______

Education Information:

U.S. Dental School Attended ___________________________Year Graduated______________

☐ General ☐ Specialist, Specify __________________ Board Eligible? ☐Yes ☐ No

Specialty School Attended_____________________________ Year Graduated _______________

Do you have hospital privileges? ☐Yes ☐No

Hospital Name ______________________________ Address ____________________________

City/State/Zip __________________________________ Phone ___________________________

(Please turn page)

Licensure & Professional Liability Information:

License #________________State ____________Expiration Date________________

Malpractice Insurance Carrier ________________________Phone_________________

Policy Number __________________Amount of Liability___________/___________

Effective Date ___________Expiration Date___________

DEA Number ______________________ Expiration Date __________________

Please attach 1) a copy of current malpractice insurance showing name and address of carrier, doctor's name expiration date and limits of liability 2) a copy of pocket dental license 3) a copy of DEA 4) a copy of CPR for the billing provider and all associates.

Confidential Information:

Has your license to practice dentistry ever been revoked, suspended or have you been placed on probation by a licensing agency? ☐Yes ☐No

Has your DEA license ever been revoked, suspended or have you been placed on probation? ☐Yes ☐No

Have you ever been indicted for, pled guilty or nole contendere or have been convicted of a felony or a crime of moral turpitude? ☐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 at any stage of the litigation including preliminary notice of suit and appeal? ☐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 or accused you in writing of unlawful activity? ☐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)__________________________
____

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 LBA.

Doctor's Signature:_______________________________________Date:____________________