LIBERTY DENTAL PLAN

Provider Credentialing Application

*Required Fields

Please complete one application per Provider.

CREDENTIALING INFORMATION:

☐ **Owner** ☐ **Associate**

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

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

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

***PRIMARY PRACTICE ADDRESS:** _____

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

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

Email Address:

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

* **NPI Type 1** (Individual): _____ NPI Type 2 (Organizational): _____

(More than one provider in the office requires an Organizational NPI Number)

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

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

EDUCATION INFORMATION:

***SPECIALTY TYPE:** ☐ General Dentist ☐ Endodontist ☐ Pediatric Dentist ☐ Periodontist
☐ Oral Surgeon ☐ Orthodontist ☐ Prosthodontist ☐ Other _____

***BOARD CERTIFIED:** ☐ YES ☐ NO (Please Check "NO" if not applicable. Do not leave blank.)

***DENTAL SCHOOL ATTENDED**: _____ **MONTH / *YEAR GRADUATED:** ___/_____

***CITY**: _____ State: _____ Country: _____

Specialty School Attended: _____ **MONTH / YEAR GRADUATED:** ___/_____

City: _____ State: _____ Country: _____

***Do you have Hospital Privileges?** ☐ YES ☐ NO (Please Check "NO" if not applicable. Do not leave blank.)

Hospital Name: City/State/Zip: Phone #: ( ) -

*Do you have current and valid state issued permits to administer Oral, Enteral, Parenteral, Intravenous, Inhalation, Conscious and/or Pediatric Conscious Sedation? ☐ YES ☐ NO

IF YES, please check all permits that you maintain and that apply to your licensure in the state you are applying for:

☐ Oral/Enteral Sedation ☐ Parenteral Sedation ☐ Intravenous Sedation ☐ Inhalation Sedation
☐ General Anesthesia ☐ Conscious Sedation ☐ Pediatric Conscious Sedation

Alternative Languages Spoken?

LICENSURE and PROFESSIONAL LIABILITY INFORMATION:

***Please attach a copy of your current:** 1) Dental License 2) DEA 3) Malpractice Insurance Cert showing Professional Liability*

***LICENSE #:** _____ State: _____ ***EXPIRATION DATE**: _____

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

***MALPRACTICE INSURANCE CARRIER:** _____ ***EXPIRATION DATE**: _____

***POLICY #:** _____ ***AMOUNT OF LIABILITY:** $ /$ _____

*5 YEAR WORK HISTORY:

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

1. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** **CURRENT**

2. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** MONTH / YEAR ___/_____

3. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** MONTH / YEAR ___/_____

4. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** MONTH / YEAR ___/_____

5. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** MONTH / YEAR ___/_____

6. DENTAL PRACTICE NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FROM DATES: MONTH / YEAR ___/_____ **To:** MONTH / YEAR ___/_____

***PROFESSIONAL QUESTIONS and ATTESTATIONS: (ALL questions must be answered)**

For each "YES" response please include a detailed explanation with this form.
Please check "NO" for any questions that are NOT APPLICABLE.

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 provide the reason(s) for any gap(s) on a separate page. Please mark "NO", if any gaps occur between 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, canceled, sanctioned, or subjected to any disciplinary action? 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, 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, engaged 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 pleaded "nolo contendere" to a felony?
   ☐ **YES** ☐ **NO**
10. Have you been involved, within the last ten 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 incidents(s), your involvement, current disposition, and the amount of settlement.
    ☐ **YES** ☐ **NO**
11. Are you currently practicing WITHOUT, or with and 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 network participation with **LIBERTY Dental Plan.**

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

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

Information Release / Acknowledgments:

I authorize **VerifPoint/CreDENTIALs** or any **LIBERTY Dental Plan 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 (under "Credentialing Information") by and between LIBERTY Dental Plan and other Healthcare Organizations (e.g. hospital medical staff, 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, businesses and individuals acting as their agents (collectively, "HealthCare Organizations), for the purpose of evaluating this application and re-credentialing application regarding my professional training, experience, character, conduct, judgment, ethics, 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 evaluation the qualifications of healthcare providers. 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, from an liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation with LIBERTY Dental Plan, to the extent that those acts and/or communications are protected by state and federal law.

I, the undersigned, hereby certify that the information requested by the CVO 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 CVO. The undersigned hereby agrees to notify the CVO of any changes in the above information.

I understand that if LIBERTY Dental Plan denies my application or otherwise takes action that is adverse to my request for participation, LIBERTY Dental Plan and/or its Representatives may be obligated, under applicable law, to report such action to the National Practitioner Data Bank and/or other licensing or accreditation agencies.

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

(No Signature Stamps)

***PRINT NAME:** _____

ADDENDUM TO LIBERTY DENTAL PLAN PARTICIPATING PROVIDER APPLICATION

NOTICE OF PROVIDER 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.