LIBERTY DENTAL PLAN

Dental Hygienist - Credentialing Application

*Required Fields

Please complete one application per Dental Hygienist

Demographic Information:

☐ Male ☐ Female

***HYGIENIST NAME:** _____ ☐ RDH ☐ Other _____

***DATE OF BIRTH:** _____ ***SOCIAL SECURITY # :** _____

***DENTAL PRACTICE NAME:** _____

***PRACTICE ADDRESS:** _____

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

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

Office Contact Name: _____ **Email**: _____

Education Information:

***Hygienist School Attended**: _____ **Month/*Year Graduated**: _____

City: _____ State: _____ **DEGREE:** _____

Other School Attended: _____ **Month/ Year Graduated**: _____

City: _____ State: _____ **DEGREE:** _____

Licensure Information:

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

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

***Medicaid ID #:** _____

Professional Liability Information - Covered Under:

*If covered under the Individual Dentist Policy or Dental Practice's Policy, Hygienist Name must either appear on the Insurance Certificate or a letter from the office must accompany the Insurance Certificate, stating the Hygienist is covered under the Insurance Certificate showing Dental Hygienist Name and Insurance Certificate Policy Number in the letter.

☐ Individual Policy –(Showing Dental Hygienist Name) ☐ Individual Dentist's Policy ☐ Dental Practice's Policy

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

*Policy #: _____ *Amount of Liability Coverage $ / $

*Dental Practice or Dentist's Name: _____

*5 Year Work History:

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

1. DENTAL PRACTICE NAME: (Current Location)

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

LIBERTY Dental Plan Questions:

1. Have you completed education/training in the prevention, transmission and treatment of AIDS? ☐ Yes ☐ No
2. Do you speak any alternative languages? ☐ Yes ☐ No - Please specify: _____

***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.**

***Dental Hygienist 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.

***Dental Hygienist Signature:** _____ ***Date:** _____

(No Signature Stamps)

***Print Name:** _____

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.