LIBERTY DENTAL PLAN
Provider Credentialing Application

(Complete one application per Provider)

Credentialing Information:

Owner: ☐ **Associate:** ☐

(* Required Fields)

***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) ____________________

State Billing # ____________________ State Rendering # ____________________

Education Information:

***Dental School Attended**: ____________________ ***Year Graduated**: ________

Specialty School Attended: ____________________ Year Graduated: ________

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

Do you have hospital privileges? ☐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:** ____________________ Phone: ________

Policy #: ____________________ Amount of Liability: ________

Effective Date: ____________________ **EXPIRATION DATE:** ________

*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:**

Month / Year

From Dates: / **to** **Current**

PRACTICE NAME:

Address:

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

Month / Year Month / Year

From Dates: / **to** /

PRACTICE NAME:

Address:

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

Month / Year Month / Year

From Dates: / **to** /

PRACTICE NAME:

Address:

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

Month / Year Month / Year

From Dates: / **to** /

PRACTICE NAME:

Address:

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

Month / Year Month / Year

From Dates: / **to** /

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 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, 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 wit the affiliated organization contracted with the VerifPoint/CreDENTALs. The undersigned hereby aggress to notify VerifPoint/CreDENTALs of any changes in the above information.

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

DOCTOR'S SIGNATURE: ______________________________ **DATE:** __________

(No Signature Stamps)

PRINT NAME: ______________________ **LICENSE #:** __________ **STATE:** __________