Dental Network of America®

CREDENTIALING APPLICATION

PLEASE COMPLETE ALL ITEMS TO AVOID DELAYS IN PROCESSING

ATTN: **Provider Support**

PHONE: **630-401-2676** FAX: **312-565-1921** EMAIL: **bbuzea@dnoa.com**

MAILING ADDRESS: **1020 31st Street, Downers Grove, IL 60515**

1) GENERAL INFORMATION

Complete the front and back of this application (1 per dentist).

First Name: | Middle Name:

Last Name: | Suffix: ☐ SR ☐ JR ☐ III ☐ IV | Gender: ☐ Male ☐ Female

Individual NPI Number (Type 1): | Date of Birth: (MM/DD/YY) | Social Security Number: (kept confidential)

Specialty: ☐ General Dentist ☐ Endodontist ☐ Pediatric Dentist ☐ Orthodontist ☐ Periodontist ☐ Oral Surgeon ☐ Prosthodontist | Dentist languages spoken other than English, please list:

Primary Office Name:

Address: | City: | State: | Zip:

Phone: | Fax:

2) LICENSE & CERTIFICATES

Certificate attachments encouraged.

Current State License Number: | State: | Expiration Date: (MM/DD/YY)

Previous State License Number: (5 year history required) | State: | Expiration Date: (MM/DD/YY)

CDS Certificate Number: | Expiration Date: (MM/DD/YY) | DEA Certificate Number: | Expiration Date: (MM/DD/YY)

Professional Liability Insurance:

YOU MUST PROVIDE A COPY OF YOUR CURRENT CERTIFICATE.

3) DENTAL EDUCATION

CV/resume accepted.

Dental School Name: | Graduation Date: (MM/YY) | Degree: ☐ DDS ☐ DMD

Specialty Training/Institution Name: | State: | Did you successfully complete the program? ☐ Yes ☐ No | Completion Date: (MM/YY)

Are you Board Certified? ☐ Yes ☐ No | Board Name:

Hospital Affiliation/Institution Name: | State:

4) WORK HISTORY

Past 5 years (CV/resume accepted) GAPS OVER 6 MONTHS REQUIRE AN EXPLANATION.

Current Practice/Employer Name: | Start Date: (MM/YY)

Practice/Employer Name: | Start Date: (MM/YY) | End Date: (MM/YY) ☐ Presently Employed

Practice/Employer Name: | Start Date: (MM/YY) | End Date: (MM/YY) ☐ Presently Employed

Do you have any employment gaps greater than 6 months? ☐ Yes ☐ No If yes, is this gap due to maternity leave? ☐ Yes ☐ No

If no, please explain gap:

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5) CONFIDENTIAL QUESTIONS

Please check YES or NO for ALL questions.

Use a separate sheet to explain any "YES" answers to questions 1-8 and any "NO" answers to questions 9-11.

	YES	NO	
1.	☐	☐	Are you now or have you ever been involved in any malpractice suit or arbitration, or has any settlement ever been paid by you or paid on your behalf? If YES, please explain for each suit, arbitration, or settlement (whether open or closed) all details including dates of incidents, filings, settlements; underlying circumstances; your role and legal status (defendant, co-defendant, other); subsequent events (including patient outcome); professional liability insurer involved; amounts paid; and current status.
2.	☐	☐	Has your professional liability insurance ever been denied, suspended, canceled or not renewed?
3.	☐	☐	Have you ever had any of the following items denied, revoked, suspended, not renewed, placed on probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?

YES	NO		YES	NO	
☐	☐	State license	☐	☐	DEA, CDS, or other applicable narcotic registration
☐	☐	Hospital or other health-care facility staff membership or privileges	☐	☐	Professional organization membership
☐	☐	Medicaid, Medicare or other government program participation	☐	☐	HMO, PPO, or other managed care plan
☐	☐	Employment as a health-care provider by a military service, hospital, HMO, or other health-care organization			

4.	☐	☐	Do you have any physical or mental impairment or condition that, with or without accommodation, would make you unable to perform the essential functions of a practitioner in your area of practice or unable to perform such essential functions without a direct threat to the health and safety of others?
5.	☐	☐	Consider the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that would pose a significant health and safety risk to your patients?
6.	☐	☐	Within the past five years up to and including the present, have you ever had a chemical dependency or substance abuse problem that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?
7.	☐	☐	Have you ever been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime?
8.	☐	☐	Have you ever been subject to any peer-review type of action?
9.	☐	☐	Does your office utilize proper infection control and barrier techniques?
10.	☐	☐	Does your office comply with OSHA requirements?
11.	☐	☐	Does your office have 24-hour emergency service or otherwise conscientiously make arrangements for emergency care, such as an answering service or machine with your home phone number, for your patients of record?

6) AUTHORIZATION & RELEASE

I authorize Dental Network of America, LLC. and its subsidiaries, affiliates and parent company ("DNoA") and its clients who perform credentialing related services including, but not limited to, Dentistat, Inc.® ("clients"), to obtain information from others including state licensing authorities, certification boards, professional liability insurance carriers (including claim histories and loss reports), hospital, substance-abuse programs, and health-care-related employers, about my qualifications, including without limitation, my professional competence and conduct. I further authorize, DNoA and its clients, to release information on this form to their parent organizations, affiliates, subsidiaries, employees, and agents.

I consent to the release to DNoA and its clients any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged. I release DNoA and its clients, and any persons or entities providing information to DNoA and its clients or evaluating the information received or provided on this form, from any and all liability, providing their acts were performed in good faith and without malice.

I understand I have the burden of providing adequate information to DNoA and its clients to demonstrate my qualifications. I understand and agree that any misstatement or material omission on this form may constitute grounds for rejection of my application or dismissal as a member or participating provider with DNoA or its client-sponsored networks. I understand and agree that it is my obligation to immediately notify DNoA if any materials changes occur in the information I have provided on this form. I understand that statements written on this form will be considered statements made by me, even if prepared by an employee, agent, or representative.

I attest that the information contained on this form is correct and complete.

Dentist Signature: (Original signature only – NO STAMPS)

Dentist Name: (Printed)	**Date:** (MM/DD/YY)

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PRACTICE APPLICATION

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1) GENERAL PRACTICE INFORMATION

Only 1 TIN allowed per Practice Application: make copies for additional TIN's.

TIN: (Tax ID number used for claims)	TIN Type: ☐ EIN ☐ SSN **This TIN must match the TIN on your W-9 Form**	Practice/Group NPI Number (Type 2):
Practice Legal Name: (must match the name listed on the first line of your W-9 Form)		
Practice/Directory Name/Doing Business As (DBA):		

Alternate Claims Payment Address: (only if different than an office listed below: checks will be mailed to this address for all offices listed below)	City:	State:	Zip:
Practice Contact:	Phone:		
Fax:	Website:		
E-mail:			

2) AFFILIATED OFFICE INFORMATION

Make copies and attach for additional offices.

OFFICE #1 Office Name (Primary):

Address:	City:	State:	Zip:
Office Contact:	Phone:		
Fax:	Languages Spoken:		

OFFICE #2 Office Name:

Address:	City:	State:	Zip:
Office Contact:	Phone:		
Fax:	Languages Spoken:		

OFFICE #3 Office Name:

Address:	City:	State:	Zip:
Office Contact:	Phone:		
Fax:	Languages Spoken:		

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3) ADDITIONAL OFFICE INFORMATION

	MON	TUE	WED	THUR	FRI	SAT	SUN
OFFICE HOURS:							

How is your office phone answered after hours?
☐ Service ☐ Voice Mail

Describe your emergency coverage:

4) PARTICIPATING DENTIST INFORMATION

Make copies and attach for additional dentists.

DENTIST #1 First Name: (as desired for listing in network directory)

Last Name:

License Number:

Individual NPI Number (Type 1):

Office(s) where dentist practices: (refer to Office #'s listed on page 1, section 2)
☐ Office #1 ☐ Office #2 ☐ Office #3

Specialty:
☐ Endodontist ☐ Oral Surgeon ☐ Pediatric Dentist
☐ General Dentist ☐ Prosthodontist ☐ Orthodontist ☐ Periodontist

DENTIST #2 First Name: (as desired for listing in network directory)

Last Name:

License Number:

Individual NPI Number (Type 1):

Office(s) where dentist practices: (refer to Office #'s listed on page 1, section 2)
☐ Office #1 ☐ Office #2 ☐ Office #3

Specialty:
☐ Endodontist ☐ Oral Surgeon ☐ Pediatric Dentist
☐ General Dentist ☐ Prosthodontist ☐ Orthodontist ☐ Periodontist

DENTIST #3 First Name: (as desired for listing in network directory)

Last Name:

License Number:

Individual NPI Number (Type 1):

Office(s) where dentist practices: (refer to Office #'s listed on page 1, section 2)
☐ Office #1 ☐ Office #2 ☐ Office #3

Specialty:
☐ Endodontist ☐ Oral Surgeon ☐ Pediatric Dentist
☐ General Dentist ☐ Prosthodontist ☐ Orthodontist ☐ Periodontist

DENTIST #4 First Name: (as desired for listing in network directory)

Last Name:

License Number:

Individual NPI Number (Type 1):

Office(s) where dentist practices: (refer to Office #'s listed on page 1, section 2)
☐ Office #1 ☐ Office #2 ☐ Office #3

Specialty:
☐ Endodontist ☐ Oral Surgeon ☐ Pediatric Dentist
☐ General Dentist ☐ Prosthodontist ☐ Orthodontist ☐ Periodontist

5) AUTHORIZING SIGNATURE

I certify that all the information provided herein is correct and complete and I agree to notify DNoA promptly should any change occur in the information I have provided on this form.

Authorized Signature:

Authorized Name: (Printed)

Date: (MM/DD/YY)