P.O. Box 631
Worcester, MA 01613
844-MH-DENTL

Please Complete and Sign One Copy per Practitioner

Practitioner Name:	
Practice Name:	

Please Check one of the following:

☐ Enrolling Individual Provider as a Sole Proprietor or Independent Provider
☐ Enrolling Individual Provider with a New Group Practice
☐ Enrolling Individual Provider with an Existing Group
☐ Changing from a Sole Proprietor to a Group Practice

☐ Changing Tax Identification Information

CONFIDENTIAL CREDENTIALING APPLICATION

Credentialing application must be completed for each participating dentist in the practice.
BeneCare's credentialing process is conducted in a non-discriminatory manner and the credentialing committee's approval or denial of participation status is not determined on the basis of race, color, national origin, sex, age, religion, ancestry, marital status, sexual orientation, place of residence, health status, area of residence, diagnosis, handicap, source of payment, or otherwise.

Notification of your acceptance or denial will be given within 30 days of the Credentialing Committee's decision. In the event BeneCare's Credentialing Committee denies your application for participation, you have the right to: 1) review any adverse findings that may have led to the denial and 2) appeal the Committee's decision, in writing and within 30 days from the date of notification.

Check items attached:

- ☐ Completed Credentialing Form (including signature pages)
- ☐ The Doctor's Dental License
- ☐ The Doctor's DEA Certificate Number (Federal Drug License)
- ☐ The Doctor's current Malpractice Insurance Certificate Face Sheet
- ☐ If Board Certified, a copy of the Certificate of Certification
- ☐ Signed Credentialing Attestation

Office Contact Person:

_____ _____

(Name) (Position)

(_____)_____

(Telephone Number)

_____

Email Address:

SCHEDULE 2

Required Licenses, Certifications, Accreditations and Other Qualifications.

All licenses, certifications, accreditations and other qualifications that are required for the performance of the services contemplated by this Agreement, including without limitation:

1. A current, valid license to practice dentistry in the State(s) of the Practioner's practice that is not restricted.
2. A current, valid, DEA permit, where applicable, that is not restricted.
3. A current, valid permit authorizing the use of general anesthesia or conscious sedation, as applicable.
4. Active Medical Staff privileges at a hospital if such privileges are necessary for the practice of the Practitioner's specialty, as determined by DBMI.

Email Address:

_____

OFFICE INFORMATION

	Office Location I	**Office Location II** (if applicable)	**Office Location III** (if applicable)
Street Address			
Town, State, Zip			
Phone Number			
Fax Number			
Internet Address			
Group, Partnership or Corporate Name			
Federal Tax ID Number ☐ OR **Social Security Number** ☐ (ID that claims are filed under)			
Practice (Type II) NPI Or Billing NPI			
Type of Practice (check one only)	☐ - Solo ☐ - Group ☐ - Other/Specify:	☐ - Solo ☐ - Group ☐ - Other/Specify:	☐ - Solo ☐ - Group ☐ - Other/Specify:
Office Hours: (list by day of week)	Sun Mon Tue Wed Thu Fri Sat	Sun Mon Tue Wed Thu Fri Sat	Sun Mon Tue Wed Thu Fri Sat
Language(s) Spoken other than English: In Office ☐ By Dentist ☐			
Is Office Wheelchair Accessible?			

CONFIDENTIAL CREDENTIALING SUBMISSION

DENTIST'S DEMOGRAPHIC INFORMATION:

Dentist's Last Name	
Dentist's First Name	
Dentist's Middle Initial	
Date of Birth	
Gender	
Dentist's NPI Number (Type I, Individual)	
Dentist's Specialty (select one)	◯ General Dentist | ◯ Endodontist | ◯ Pediatric Dentist Oral Surgeon | ◯ Orthodontist | ◯ Periodontist
Dental School (Institution, City, State, Degree, Graduation Date *MM/YYYY*)	

HOSPITAL AFFILIATIONS:

Hospital(s) at which you have admitting privileges (indicate type of privileges) if applicable.

Hospital Name & Address	Type(s) of Privileges	Discharges per Month

BOARD CERTIFICATION (Please include a copy of your certificate(s):

Specialty	Board Certified (Y/N)	Certification Date	Certification Number	Re-Certification Date

DENTIST'S PRACTICE HISTORY:

		YES	NO
1.	Has your license to practice dentistry in any jurisdiction ever been limited, suspended or revoked?	☐	☐
2.	Have you ever been or are you currently under investigation, or involved in any proceeding involving your practice, before any state licensing board?	☐	☐
3.	Have you ever been denied a state or federal certificate or authority to prescribe narcotics?	☐	☐
4.	Has your state or federal authority to prescribe narcotics ever been revoked or otherwise limited?	☐	☐
5.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action by any dental organization?	☐	☐
6.	Have you ever been sanctioned by a specialty board, or has your specialty certification ever been suspended or revoked?	☐	☐
7.	Has your eligibility to participate in any Medicaid program ever been suspended or terminated in any state?	☐	☐
8.	Have you ever been convicted of any offense other than a minor traffic violation, including but not limited to:	☐	☐
a.	Crimes related to the delivery of service under Medicare or Medicaid?	☐	☐
b.	Crimes related to the abuse or neglect of patients in connection with the delivery of health care?	☐	☐
c.	Crimes involving fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of health care or involving any act or omission in a program financed in whole or in part by any federal, state or local government?	☐	☐
d.	Obstruction of justice?	☐	☐
e.	Crimes related to the manufacture, distribution, prescription or dispensing of any controlled substance?	☐	☐
f.	Other?	☐	☐
9.	Have you ever been assessed a civil penalty by anyone for false or fraudulent submittal of claims for payment, or other violation of payment practice standards?	☐	☐
10.	Have you ever been denied hospital or other health care facility privileges?	☐	☐
11.	Have your hospital or other health care facility privileges ever been canceled, challenged, reduced, limited, suspended, not renewed, revoked or voluntarily withdrawn?	☐	☐
12.	Are you dependent upon any controlled substance or alcohol?	☐	☐
13.	Do you have any physical, mental or emotional condition that would compromise your ability to practice in any way?	☐	☐
14.	Have you ever been reported to the National Practitioner Data Bank by any state licensing authority, dental society or association or any hospital or health care facility?	☐	☐

PROFESSIONAL LIABILITY COVERAGE (minimum coverage of $1,000,000-$3,000 00 required)

		YES	NO
15.	Has any malpractice or professional liability claim been brought against you within the last 10 years? If so, please describe the case on a separate page, and indicate the current status, if pending. If closed or settled, state the amount of any settlement on your behalf.	☐	☐
16.	Have you ever been denied professional liability coverage?	☐	☐

Please attach a current certificate of malpractice insurance coverage. Insert malpractice claim and/or board action explanation if you answered YES to questions 15 or 16 above.

UTILIZATION REVIEW

If you answer yes to either of the following questions, please summarize comments and recommendations on a separate sheet.

		YES	NO
17.	Have you been the subject of peer review proceedings brought by a hospital or health care facility, by a dental society or association, or by a state or federal authority?	☐	☐
18.	Have you ever been sanctioned by any hospital, health care facility, state or federal authority for practice patterns or for inappropriate or inadequate care?	☐	☐

WORK HISTORY

A chronological listing, including MONTH and YEAR, of current and previous employment history for the most recent five years is required. Please include all armed services, public health, educational, business or professional activities, including sabbaticals, as applicable. LEAVE NO GAPS IN THE CHRONOLOGY.

Dates (Month/Year)	Facility & Address	Telephone & Tax ID	Reason of Leaving
From: _____/_____ To: _____/_____			
From: _____/_____ To: _____/_____			
From: _____/_____ To: _____/_____			
From: _____/_____ To: _____/_____			
From: _____/_____ To: _____/_____			
From: _____/_____ To: _____/_____			

PROVIDER STATEMENT:

All information submitted by me in this application is true to my best knowledge and belief. I understand that any of this information which is subsequently found to be false could result in denial of this application or loss of membership in or privileges with BeneCare Dental Plans and its affiliates, clients, related Independent Practice Associations or Managed Care clients.

I understand and agree that I have the responsibility for producing adequate information for proper evaluation of my qualifications and for addressing any concerns about such qualifications. I also agree to provide pertinent information which is relevant to this submission, as requested, at a later date.

I authorize and consent to the release of information to BeneCare about me and my professional practice by hospitals, or other persons or organizations. I agree not to bring any administrative proceeding or take any judicial action against BeneCare or its personnel for receiving and using the information, or any person or institution for providing the information to BeneCare.

I authorize release of my malpractice history from my insurance carrier and release of pertinent information concerning me from Utilization Review Organizations or Peer Review Organizations. I hereby hold the sources of such information harmless for release of this information to BeneCare.

I agree to adhere to the Principles of Ethics of the American Dental Association. I will also adhere to the Bylaws, Rules, and Regulations of any hospitals at which I have privileges.

_____ _____

(Date) (Signature of Doctor/Hygienist)