

CREDENTIALING APPLICATION

**This Credentialing Application cannot be processed until it is completed in full.
Please maintain a copy of this Credentialing Application for your records.**

Credentialing Application is complete when:

- The Credentialing Application has been SIGNED and UPDATED.
(DDNE does NOT accept STAMPED SIGNATURES)
- Current COPIES of the following have been attached:
 - ✓ Dental License (provide copies for EVERY state in which you are licensed)
 - ✓ DEA Registration for **EVERY STATE** the DDS is practicing in (or documentation DEA is pending)
 - ✓ Board/Specialty Certificate (if applicable)
 - ✓ Professional Liability Insurance Declaration Page - to include effective and expiration dates, insurance carrier, and coverage limits of no less than \$200,000/\$600,000 and name of each provider covered. If expiration date is within weeks of this application, updated documentation must be submitted.
- W-9 Form or Taxpayer Identification Number Request
- Confidential Filed Fee Schedule **OR** note stating taking on clinics existing filed fee schedule

Please attach SIGNED contracts for each network you wish to participate in as follows:

- Dentist Membership and Participation Agreement (Delta Dental Premier)
- Delta Dental PPO

MAIL CREDENTIALING APPLICATION TO:

Delta Dental of Nebraska
Attn: Credentialing
P.O. Box 9304
Minneapolis, MN 55440-9304
FAX: (toll free) 866-286-8840

QUESTIONS? Call (toll free) 800-328-1188 x4170

Notice of Applicant's Right

You may review your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable Nebraska state laws. If there are discrepancies in the information received during the credentialing process, you will be notified and allowed an opportunity to correct erroneous information submitted by another party within thirty (30) days to your application. This includes information submitted by an outside primary source, such as Professional Insurance Carrier, State License Board and/or the National Practitioner Data Bank-Healthcare Integrity Protection Data Bank.

Confidentiality Statement

Delta Dental of Nebraska (DDNE) maintains all information gathered as part of the credentialing or re-credentialing process in a confidential manner and will not communicate or reproduce any information obtained during the process. DDNE strictly enforces the provisions designed to safeguard information and ensure confidentiality.

DEMOGRAPHICS (Please type or print)

STATE DENTAL LICENSE #: _____

Name:	_____		
	Last	First	MI
Social Security Number:	____ - ____ - _____		
Individual NPI:	____ - _____ - _____		
Date of Birth:	____ / ____ / _____	Do you currently hold a DEA registration? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	DDS' Initials _____
Languages Spoken Fluently:	_____		
Home Address and Phone:	_____		

PRIMARY PRACTICE LOCATION

Primary Office:	_____		
	Group Name and Clinic Name (if different) _____		
Street Address:	_____		
City/State/Zip:	_____	County:	_____
Office Phone Number:	(____) _____	ER/After Hours Number:	(____) _____
Fax Number:	(____) _____	Handicap Accessible	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tax ID Number (TIN):	____ - ____ - _____		
Corporate NPI:	____ - _____ - _____		
Office Manager/Contact:	_____	Office Email:	_____
If MORE THAN ONE location please attach a SEPARATE SHEET with the above information.			

BILLING INFORMATION (If different from information given above)

Billing Name:	_____		
Billing Address:	_____		
Office Manager/Contact:	_____		
Billing Phone Number:	(____) _____		
Billing Tax ID Number (TIN):	____ - ____ - _____		

GENERAL DENTISTRY EDUCATION

Institution _____	Grad Date _____	Degree _____
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SPECIALTY EDUCATION

Institution _____	Specialty _____	Grad Date _____	Degree _____
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For the above specialty, I am: Educationally Qualified (attach copy of specialty certificate)
 Board Certified * (attach certificate copy from Specialty **Board**)

* Date of Certification: _____ Expiration Date: _____

EMPLOYMENT HISTORY: Chronological listing must include MONTH and YEAR for each entry of employment history for the most recent 5 years. List all armed service and public health, education, business or professional activities, sabbatical, etc. LEAVE NO GAPS IN CHRONOLOGY.

Dates (Month & Year)	Facility and Address	Reason for Leaving:
From: _____ To: _____ Present	Current Location	
From: _____ To: _____ _____/_____/_____/_____		
From: _____ To: _____ _____/_____/_____/_____		

PRIMARY ADMITTING FACILITY (List present hospital/surgical center privileges in chronological order beginning with the most recent.)

Primary Admitting Facility: Type of Status: Street Address: City/State/Zip: Dates (Month/Year):	_____ _____ _____ _____ From: _____ To: _____
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DISCLOSURE QUESTIONS

Please complete the Professional Liability Addendum in this application if any of the following questions are answered in the affirmative.

- Yes No Have you ever had your **professional license, registration or DEA** terminated, stipulated, restricted, limited, conditioned, subjected to corrective action, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?
- Yes No Have you ever had your **membership, participation, clinical privileges, or employment** denied, terminated, stipulated, restricted, refused, limited, subjected to corrective action, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?
- Yes No Have you ever voluntarily/involuntarily relinquished your **membership, participation, clinical privileges or request for privileges, employment, professional license, or registration** as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?
- Yes No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you been subject to a corrective action agreement/plan with any **licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**
- Yes No Have you ever had your certificate or participation in **any private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?
- Yes No Are there any **charges pending** or have you ever been indicted, found guilty of a felony, misdemeanor (other than a minor traffic violation), or other offenses involving fraud, misrepresentation, dishonesty or deceit? Are you currently using illegal drugs?
- Yes No Have you ever been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment?
- Yes No Have you ever had any Malpractice (Professional Liability) claims or lawsuits brought against you, including pending, dismissed or dropped claims/lawsuits, settlements or final judgments? (This includes status of any pending claims previously reported.) Have you ever had your Malpractice (Professional Liability) carrier refuse or cancel your coverage?
- Yes No Do you have a condition in which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing a significant health or safety risk to your patients?

PROFESSIONAL LIABILITY ADDENDUM

COMPLETE addendum if you answered "YES" to any Disclosure Questions.
Attach separate sheet if necessary.

Malpractice Claim(s)

Date of Occurrence: _____ Settlement Amount: _____
Name & Address of Insurance Carrier _____
Current Status of Claim: _____ Date Claim Resolved: _____
Details of Allegations: _____

Board Action(s)

Date of Occurrence: _____ Date of Satisfaction/Closure: _____
Amount of Fine Paid: _____
Details of Action (conditions, limitations, etc.) Attach copy of Board Action/Corrective Action: _____

DISCLOSURE QUESTIONS & PROVIDER CONSENT

I hereby certify that to my knowledge that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains so while my application is being processed. I certify that my office protocols for infection control are in compliance with current CDC/OSHA guidelines. I agree to notify Delta Dental of Nebraska (DDNE) of any changes in malpractice coverage, including changes in the insurance carrier or policy number, as they occur.

By completing this application to become a participating provider with DDNE or any DDNE affiliate or a network administered by DDNE. I fully understand that any significant misstatement in, or omission from, my application to become a participating provider may constitute cause for denial of my application or the subsequent termination of my participating provider contract if my application is accepted. I understand and agree that this consent is irrevocable for any period during which I am a participating provider with DDNE. DDNE reserves the right to base acceptance into any individual network based on criteria established by DDNE.

I understand that my application may require DDNE to review information related to me on file with other entities, including but not limited to, state licensing boards, specialty boards, professional societies, malpractice carriers, and the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank administered by the U.S. Government.

I authorize release from liability all representatives of DDNE, including any agent of DDNE, my state licensing board, clinics, other institutions, professional societies, professional malpractice insurance carrier(s) and any staff, for their acts performed in good faith and without malice in connection with the gathering and exchange of information as consented above or to release information as required by State or Federal laws, rules, or regulations.

I understand and agree that I have the responsibility of producing adequate information for proper evaluation of my continued professional competence, ethics and other qualifications and for resolving any doubts about such qualifications. I further understand and agree that I have a continuing affirmative duty to immediately inform DDNE of any future restrictions or revocation of my professional license, any disciplinary action, suspension or voluntary/involuntary limitation, denial of my clinical or other privileges, or any other event which may adversely reflect upon my professional competence, ethics and other qualifications as a participating provider.

I understand that subject to proper confidentiality restrictions and authorizations, my dental records will be subject to inspection by DDNE for quality assurance and utilization review purposes.

Signature _____ **Date** _____

Name _____

(please print or type)

Delta Dental of Nebraska's selection process ensures that Credentialing decisions are not based on an applicant's race, ethnicity/nationality, gender, age, sexual orientation, or the types of patients or procedures in which the dentist specializes.