



Diversified Dental Services, Inc.

APPLICATION FOR PARTICIPATION INITIAL CREDENTIALING APPLICATION

PERSONAL DATA

Name _____ Date of Birth _____
 Other Name (s) Previously Used _____ Effective _____
 Social Security Number _____ UPIN# _____ Medicaid _____
 Medicare# _____ NPI Type 1 (Personal) _____ NPI Type 2 (Corporate) _____
 Local Residence: _____
 Address _____ Phone _____

PROFESSIONAL LICENSES

Dental License # _____ Date Issued _____ Date Expires _____
 Other State Licenses:

State	Number	Issue Date	Expiration Date

DEA REGISTRATION

Attach copy of certificate

Federal DEA Registration # _____ Date Expires _____
 State Pharmacy (if applicable) # _____ Date Expires _____
 Other State Pharmacy Licenses:

State	Number	Issue Date	Expiration Date

EDUCATION/TRAINING

DENTAL EDUCATION

Facility Name _____
 Mailing Address _____
 Phone _____ FAX _____
 FROM: Mo/Yr _____ TO: Mo/Yr _____ Degree Earned _____

Facility Name _____
 Mailing Address _____
 Phone _____ FAX _____
 FROM: Mo/Yr _____ TO: Mo/Yr _____ Degree Earned _____

DENTAL EDUCATION (con't)

Internship/Residency (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Degree Earned

OTHER POST GRADUATE EDUCATION

List in chronological order and include copies of certificates

Facility Name

Specialty & Degree Awarded

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

HOSPITAL AND OTHER HEALTH CARE ENTITY MEMBERSHIPS

List ALL hospitals and surgical centers where you currently have or have had affiliation, membership and/or have been granted privileges. If you have withdrawn an application or you are no longer affiliated with a hospital or surgical center; provide an explanation on a separate page. If an explanation is attached, make sure the original entry is denoted. For any time period not covered by an affiliation or training, please provide a written explanation.

Hospital/Surgical Center

Affiliated With

FROM: Mo/Yr

TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

Staff Category _____ () Check here if explanation is attached

BOARD CERTIFICATIONS

Attach copies of certificate (s)

This section pertains to specialty boards that are organized and recognized by the American Dental Association.

Name of Specialty Board

Mailing Address

Date of Certification _____

Expiration Date _____

If **not** certified, indicate current status _____

If **not** certified, are you scheduled to take the exam? If so, when? _____

If you have ever failed a board examination, please indicate Board and date _____

PRIVATE PRACTICE AND OTHER

List any private practice affiliations or other employment since completion of dental school. For any time period **not** covered by an affiliation or training, please provide a written explanation.

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

PEER RECOMMENDATIONS

Criteria for peer references include: Local practitioners with your same level of licensure (e.g. MD/DO, DDS/DDS, DMD/DDS, DPM/DPM, APN/APN, PA/PA, RNFA/RNFA, etc.), personal knowledge of your current clinical abilities, ethical character and ability to work with others. Unacceptable references include relatives, current or pending professional partners/financial associates. Recommended peers: Hospital department chairs, practitioners in your specialty with whom you have worked a minimum of two of these peers should be of your same specialty. If this is not possible, please provide a written explanation.

Name _____ Specialty _____
Address _____
Telephone _____ Fax _____

Name _____ Specialty _____
Address _____
Telephone _____ Fax _____

Name _____ Specialty _____
Address _____
Telephone _____ Fax _____

PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE

Present Carrier _____

Mailing Address _____

Phone _____ FAX _____

Policy # _____ Effective Date _____ Expiration Date _____

Amounts of Coverage: Occurrence/Claim \$ _____ Aggregate \$ _____

PRACTITIONER QUESTIONNAIRE

If answers to any of the following questions is YES, please provide full details on a separate sheet, to include date of occurrence, description of events and current status.

- A. Has your license to practice medicine in any jurisdiction ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or restricted, or been made subject to a program of probation, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? YES NO
- B. Has your medical staff membership or medical staff status at any hospital or comparable acute or long term care facility or ambulatory surgery center or comparable facility, ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reason, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? YES NO
- C. Have your admitting or clinical privilege (s) at any other hospital, or at any comparable acute or long term care facility, or ambulatory surgery center or comparable facility, ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? YES NO

- D. Have you ever voluntarily or involuntarily terminated, relinquished medical staff membership or status, admitting or clinical privileges, withdrawn an application for membership or privileges at any hospital or comparable acute or long term care facility, or ambulatory surgery center or comparable facility, after notification of the actual or imminent commencement of a formal or informal review, or investigation of your practice, credentials or professional conduct? YES NO
- E. Has your membership, participation, privileges, contractual affiliation or other status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity ever been denied, revoked, voluntarily or involuntarily terminated, suspended, restricted or limited based upon patient care or professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? YES NO
- F. Have you ever voluntarily or involuntarily relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity after notification of the actual or imminent commencement of a formal or informal review or investigation, of your practice or professional conduct? YES NO
- G. Has membership or status in any state or local professional society or other comparable medical organization ever been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care or professional conduct concerns, or have formal or informal proceedings or investigations toward any of those ends ever been commenced? YES NO
- H. Has your status as a participating provider in the Medicare, Medicaid, or Tricare (formerly Champus) programs ever been sanctioned, denied, suspended, voluntarily or involuntarily terminated, limited or revoked, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? YES NO
- I. Has a letter of concern or reprimand ever been issued to you? YES NO
- J. Have you ever been denied professional liability insurance or has your policy ever been canceled? YES NO
- K. (1) Have you ever been named in a complaint based on allegations or professional negligence or professional misconduct or have you ever received notice of an intent to commence litigation of that type? Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case. YES NO
- (2) With regard to any suit, has it resulted in a judgement, a settlement, or other final disposition, or is it still pending? Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case. YES NO
- L. Does your professional liability (malpractice) coverage exclude you from performing any specific procedure (s) or practicing portions of your specialty for which you are requesting privileges? YES NO
- M. Has your specialty board certification or eligibility ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or have formal or informal proceedings, or investigation toward any of those ends ever been commenced? YES NO
- N. Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? YES NO

MALPRACTICE CLAIM INFORMATION WORKSHEET

Please duplicate this form and complete for EACH case. Also, for each case that has been settled or dismissed, supply court documentation.

Practitioner Name _____

1. Patient Name _____

2. Diagnosis _____

3. Your involvement in the case (attending, consulting, etc.) _____

4. Allegation(s) _____

5. Clinical Case Summary (Include additional pages or inserts if necessary)

6. Patient Outcome _____

7. Other Pertinent Details _____

8. Date of Incident _____ Date Filed _____ Date Closed _____

9. Resolution of Case (dismissed, settled out of court, litigated, other)

NOTE: All cases litigated must include legal documentation.

10. Settlement amount paid on you behalf, if any

11. Professional liability insurer involved:

A. Name of Insurer _____ B. Policy # _____

B. Address of Insurer

Name: _____

Signature: _____ **Date:** _____

No claims to Report

Regardless of whether you have had any claims, this form must be signed and dated.

Authorization and Releases - Required

I authorize Diversified Dental Services (DDS) and its clients to obtain information from others including state licensing authorities, certification boards, professional liability insurance carriers (including claim histories and loss reports), hospitals, substance-abuse programs, and healthcare-related employers, about my qualifications, including without limitation, my professional competence and conduct. I further authorize, DDS and its clients, to release information on this form to their parent organizations, affiliates, subsidiaries, employees, and agents.

I consent to the release to DDS of 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 DDS, and any persons or entities providing information to DDS 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 DDS 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 DDS or its client-sponsored networks. I understand and agree that it is my obligation to immediately notify DDS if any material 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 understand that my misrepresentation or significant omission in this application constitutes cause for denial or for subsequent revocation of membership and privileges. I also understand that I have an opportunity to review the information submitted in support of this application pursuant to each entity's policy regarding review. If during the process of credentialing, an entity receives information that varies substantially from information I have provided, I will be notified of this and will have an opportunity to correct erroneous information. I have the right, upon request, to be informed of the status of my application.

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

Dentist's name (please print): _____

Dentist's signature (original signature only—no stamps): _____

Date: _____