Universal Dental Provider Application

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Provider Information

First Name:	MI:	Last Name:	Suffix (Jr., Sr., etc.):	□ Male □ Female
Other Name(s) Used/Name as Appears on Dental Degree:		DOB (MM/DD/YY): ____/____/____	**Specialty:** □ Dental Assistant □ Dental Hygienist □ Denturist □ Doctor of Dental Surgery □ Doctor of Dentistry □ Dental Anesthesiology	□ Endodontic Dentist □ Oral Pathology □ Oral Radiology □ Orthodontic Dentist □ Pediatric Dentist □ Periodontic Dentist □ Prosthodontic Dentist
SSN: - -	NPI-Type1:	□ Owner □ Assoc. □ Employee □ MD □ DDS □ DMD		
Email	Medicare Number			

Licensing Information *including current license(s) and history of licensure in all jurisdictions.* Please attach current copy copies with application.

State License Number:	State:	Effective Date:____/_____/_____	Expiration Date:____/_____/_____
State License Number:	State:	Effective Date:____/_____/_____	Expiration Date:____/_____/_____
DEA Number: DEA Release:	State:	Expiration Date:____/_____/_____	□ Not Applicable
CDS Number:	State:	Expiration Date:____/_____/_____	□ Not Applicable

Refer to emergency room? □ Yes □ No

Education/Training

Dental School Name:			Degree:
Graduation Mo/Yr.:	Attended From _____/_____ To _____/_____		
Address:	City:	State:	County:
Residency/Specialty Training Institution Name:		Program/Training Type:	
Graduation Mo/Yr.:	Attended From _____/_____ To _____/_____		
Address:		City:	State:
Board Certified: Yes No	Certifying Board Name:	Certification Date:	

Specialty:

Dental Training Outside US:

Are you an American board-certified diplomat? □ Yes □ No

Work History Include work history for the past 10 years. Beginning with the most recent.

Employer	Address (City, State)	Month/Year Started	Month/Year Ended
		_____/_____	_____/_____
		_____/_____	_____/_____
		_____/_____	_____/_____
		_____/_____	_____/_____

Explain any gap in work history greater than 6 months.

Professional Liability Insurance Required: attach a current copy of your malpractice insurance declaration page.

Professional Liability Insurance Carrier			Policy No.
Policy Effective Date (MM/DD/YY): ____/____/____	Policy Expiration Date (MM/DD/YY): ____/____/____	Occurrence Limit (per claim):	Aggregate Limit:

General Liability Insurance Please attach a current copy of your malpractice insurance declaration page.

General Liability Insurance Carrier			Policy No.
Policy Effective Date (MM/DD/YY): ____/____/____	Policy Expiration Date (MM/DD/YY): ____/____/____	Occurrence Limit (per claim):	Aggregate Limit:

Hospital Affiliations If not applicable, check here

Hospital Name	Address (City, State)	Privileges	Affiliation End date
			_____/_____

Practice Information **Please note:** Providers may only have four locations listed on provider directory portal.

Attach list of additional locations as applicable.

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Primary Practice Name:					Start Date (MM/DD/YY): _____/_____/_____		
Practice Address:			City:		State:	County:	
Business URL:							
Practice Phone No.: ( )	Practice Fax No.: ( )	Tax ID (Please submit W-9)			NPI No. (Type 2/Organization) or Sub-part:		
Is Correspondence Address (if different from primary):					**Practice Type** □ Clinic □ School □ Hospital □ Academic Dental Center □ Multi Specialty Group □ Single Specialty Group	□ County □ Indian Health Services □ Mobile Unit □ FQHC □ RHC □ CHC □ Other:	
Billing Address (if different from primary):							
Credentialing Contact:		Email Address:			Phone No.: ( )		
Practice hours	Sunday	Monday	Tuesday	Wedensday	Thursday	Friday	Saturday
Provider hours at Practice	Sunday	Monday	Tuesday	Wedensday	Thursday	Friday	Saturday
Publish on Directory □ Yes □ No		Publish on Web Portal □ Yes □ No			Are translation services available? □ Yes □ No		
Have your staff completed cultural competency training? □ Yes □ No		Does your office provide access to a skilled medical interpreter? □ Yes □ No					
After Hours Coverage							
Special Needs Patients Do you accept special needs patients? □ Yes □ No							
If yes, check all that apply:							
□ ADHD □ AIDS □ Child □ Cognitive disability □ Development disabilities	□ End stage renal disorder □ Learning disabled and learning problems □ Paralysis □ Seizure disorders □ Adult □ Autism	□ Chronic illness □ Cultural competency training □ Difficulty communicating □ Hearing impaired □ Mobility limitations			□ Physical disability □ Serious mental illness □ Adult and child □ Behavioral disorders □ Co-existing disorders □ Deafness □ Duals demonstration	□ HIV □ Other □ Sedation services for members with complex medical or behavioral conditions □ Visually impaired	
Age range of special needs patients Age from_____ Age to_____		Is your office on or near a public transportation line? □ Yes □ No			Is your office handicap accessible? □ Yes □ No	Handicap Parking Available? □ Yes □ No	
Are you able to treat wheelchair confined patients? □ Yes □ No		Accepts new patients □ Yes □ No			Age of patients: from_____ to_____		

Second Practice Address

Second Practice Name:					Start Date (MM/DD/YY): _____/_____/_____		
Second Practice Address:			City:		State:	County:	
Business URL:							
Practice Phone No.: ( )	Practice Fax No.: ( )	Tax ID (Please submit W-9)			NPI No. (Type 2/Organization) or Sub-part:		
Is Correspondence Address (if different from primary):					Practice Type □ Clinic □ School □ Hospital □ Academic Dental Center □ Multi Specialty Group □ Single Specialty Group	□ County □ Indian Health Services □ Mobile Unit □ FQHC □ RHC □ CHC □ Other:	
Billing Address (if different from primary):							
Credentialing Contact:		Email Address:			Phone No.: ( )		
Practice hours	Sunday	Monday	Tuesday	Wedensday	Thursday	Friday	Saturday
Provider hours at Practice	Sunday	Monday	Tuesday	Wedensday	Thursday	Friday	Saturday
Publish on Directory □ Yes □ No		Publish on Web Portal □ Yes □ No			Are translation services available? □ Yes □ No		
Have your staff completed cultural competency training? □ Yes □ No		Does your office provide access to a skilled medical interpreter? □ Yes □ No					
Special Needs Patients Do you accept special needs patients? □ Yes □ No							
If yes, check all that apply:							

□ ADHD □ AIDS □ Child □ Cognitive disability □ Development disabilities	□ End stage renal disorder □ Learning disabled and learning problems □ Paralysis □ Seizure disorders □ Adult □ Autism	□ Chronic illness □ Cultural competency training □ Difficulty communicating □ Hearing impaired □ Mobility limitations	□ Physical disability □ Serious mental illness □ Adult and child □ Behavioral disorders □ Co-existing disorders □ Deafness □ Duals demonstration	□ HIV □ Other □ Sedation services for members with complex medical or behavioral conditions □ Visually impaired

Age range of special needs patients Age from_____ Age to_____	Is your office on or near a public transportation line? □ Yes □ No	Is your office handicap accessible? □ Yes □ No	Handicap Parking Available? □ Yes □ No
Are you able to treat wheelchair confined patients? □ Yes □ No	Accepts new patients □ Yes □ No	Age of patients: from_____ to_____	

Professional Questions and Attestation Release (Not for Use for Employment Purposes)

1.	In the last five (5) years, have you had any gaps greater than six (6) months, 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.	□ Yes	□ No
2.	Have there ever been any actions against or investigations relating to your professional license(s) in any jurisdiction?	□ Yes	□ No
3.	Have you ever voluntarily or involuntarily surrendered your license?	□ Yes	□ No
4.	Have you ever been named in any malpractice action?	□ Yes	□ No
5.	Does your current liability malpractice insurance coverage exclude any specific procedures?	□ Yes	□ No
6.	Have you been without malpractice insurance coverage in the past five consecutive years? (For healthcare Practitioners in the Commonwealth of Massachusetts: Have you been without malpractice insurance coverage in the past ten consecutive years?)	□ Yes	□ No
7.	Has your professional liability insurance coverage ever been denied, suspended, restricted, limited, modified, canceled or not renewed by the action of any insurance company?	□ Yes	□ No
8.	Have you ever been convicted of a felony, including, but not limited to, fraud, narcotics, or crimes involving children? (Misdemeanors do not need to be reported.) This statement is being answered under the penalty of perjury, subject to applicable Federal punishment for perjury. If yes, please include the disposition of the arrest or charge and explain all such occurrences in an attachment.	□ Yes	□ No
9.	Have you ever been named as a defendant in any past or pending criminal proceedings including misdemeanors (excluding traffic violations)?	□ Yes	□ No
10.	Are you prevented from performing any procedures within the scope of privileges and duties as a healthcare provider?	□ Yes	□ No
11.	Have you ever voluntarily or involuntarily surrendered membership in a professional organization/association?	□ Yes	□ No
12.	Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*	□ Yes	□ No
13.	Has there ever been any disciplinary action, suspension, probation, formal reprimand or request to voluntarily or involuntarily resign during your education, internship, residency, fellowship, preceptorship, or additional applicable training?	□ Yes	□ No
14.	Has there ever been any action against or investigation relating to your board certification (e.g. medical professional board / society) or have you voluntarily or involuntarily surrendered any board certifications?	□ Yes	□ No
15.	Has an adverse action been filed against you or have you received any disciplinary procedures regarding your participation in any private, state, or federal insurance program including Office of Personnel Management, Medicare, Medicaid or TRICARE?	□ Yes	□ No
16.	Is there any physical, mental, or substance abuse problems that would prevent you from being able to completely perform essential job-related functions, without risk to patient safety or health, with or without reasonable accommodation?	□ Yes	□ No
17.	Are you currently using any illegal substances or are you chemically dependent on alcohol, drugs, or illegal substances?	□ Yes	□ No

If you answered "yes" to any of the above questions, please explain, in detail, on the Affirmative Answer Explanation(s) page.