Confidential Re-Credentialing Information Form

This form must be completed by the contracting dentist. Your responses on this form will be used to determine whether you meet the eligibility criteria for participation in the network. Treating dentists must maintain eligibility throughout the term of their participation.

1. PROVIDER INFORMATION		
Last Name:	First Name:	Middle Initial:
Date of Birth:*	Social Security #:*	Individual NPI #:
☐ Male ☐ Female	Arkansas Issued Medicaid Number:	
Dental School:		Month/Year Graduated:
Specialty School (if applicable):		Month/Year Graduated:
☐ General Dentist ☐ Endodontist ☐ Oral Surgeon ☐ Orthodontist ☐ Pedodontist ☐ Periodontist ☐ Prosthodontist		
Are you currently American Board Certified? E Yes E No		If yes, which specialty:
List hospital for which you have privileges (List additional hospitals on back)		
Hospital:		Address:
Hospital:		Address:
ADH Prescription Monitoring Program Access Form: Registration ID#		Registration Date:

Copies of the following documents are required — Copies must be clear, legible and current			
Dental License #:		State:	Expiration Date:
Additional License #:		State:	Expiration Date:
DEA Certificate #:			DEA Expiration Date:
Do you have a current license or permit to administer conscious sedation/general anesthesia? ☐ Yes ☐ No ☐ N\A			
If yes, which type:	☐ IV Sedation	Permit #:	Expiration Date:
	☐ General Anesthesia	Permit #:	Expiration Date:
Professional Liability Insurance Co.:			Policy #:
Liability Limits Each claim:		Aggregate Claim:	Policy Exp. Date:

CURRENT SERVICE OFFICE INFORMATION			
Practice Name:			
Start Date:	Tax ID #:		Organizational NPI #:
Address:	City:	State:	ZIP:

Credentialing Contact Person	Name:	Telephone:
	Email:	FAX:

2. DENTAL WORK HISTORY FOR THE PAST FIVE YEARS

You must list a complete work history for the past five years including dates. Please provide an explanation of any work gaps greater than six months during the past five years. If you have fewer than five years of work history, please include your initial licensing date.

Practice/Group Name	Start Date (mo./yr)	End Date (mo./yr)
1.		
2.		
3.		
Explanation of gaps of six month or more	Start Date (mo./yr)	End Date (mo./yr)
1.		
2.		

3.PROVIDER CHECKLIST

For participation with **Delta Dental of Arkansas,** we must receive the following documents in order to process your application:	
☐ Complete copy of this form — "Re-Credentialing Information" ☐ Copy of the declaration page of dentist's malpractice insurance ☐ Copy of ADH Practitioner AR PMP Access Request Form ☐ Provider Facility Profile Form (One for each location)	

4. PROFESSIONAL ATTESTATION AND QUESTIONS		
To expedite the credentialing process, this page must be completed in its entirety.		
Dentist's First Name:	Last Name:	Middle Initial:
Date of Birth:	Dentist's License #:	State Issuing License:

I. Credentialing History (Please answer questions 1–11 below. For any "Yes" answer, explain on a separate piece of paper.)			
1.	☐ Yes	☐ No	Has your license to practice in any jurisdiction, whether past or still pending, been denied, restricted, limited, suspended, revoked, not renewed, placed under probation, subjected to disciplinary action, or otherwise sanctioned, limited or curtailed?
2.	☐ Yes	☐ No	Has your professional liability insurance ever been denied, suspended, revoked, canceled, or not renewed?
3.	☐ Yes	☐ No	Has your federal and/or state DEA license or applicable drug license ever been denied, suspended, canceled or not renewed, or subjected to any disciplinary action?
4.	☐ Yes	☐ No	Has your status as a provider ever been denied, suspended, canceled or sanctioned by any municipal, state, federal or any other governmental agency (e.g. Medicare, Medicaid) HMO, EPO, PPO or other prepaid health plan?
5.	☐ Yes	☐ No	Are your privileges or memberships at any hospital, institution (military service) and/or HMO currently under investigation or have they ever been denied, suspended, reduced or not renewed?
6.	☐ Yes	☐ No	Have you ever been denied membership, or renewal of membership, or been subject to disciplinary proceedings for a medical, dental or ethical reason by any dental/professional organization?
7.	☐ Yes	☐ No	Are you unable to perform any procedures within the scope of privileges and duties in your position as a health care provider, with or without reasonable accommodations required by the Americans with Disabilities Act, within accepted standards of professional performance and without posing a direct threat to patients?
8.	☐ Yes	☐ No	Do you currently, or did you in the last 5 years, engage in the unlawful use of illegal drugs, including the improper use of prescription drugs?
9.	☐ Yes	☐ No	Are you, currently or have you been in the last 5 years, addicted to or excessively used alcohol, drugs or toxic or foreign agents that tend to, in the reasonable judgment of the member company, limit or adversely affect the performance of your professional duties and responsibilities?
10.	☐ Yes	☐ No	Do you have any felony or misdemeanor charges pending against you or have you ever been convicted of a felony, or pleaded "nolo contendere" to a felony?
11.	☐ Yes	☐ No	Have you been involved in ANY malpractice (or any other civil) claims/lawsuits, settlements or judgments within the last 5 years? If yes, please provide detailed information on a separate sheet of paper including: docket number of the case, location of the court, names of the parties, plaintiff(s) and defendant(s), dates of the incident(s), description of the incident(s), your involvement, current disposition, and the amount of the settlement(s).
II. Compliance Malpractice Insurance (Answer questions 12 and 13. For any "No" answer, explain on a separate sheet of paper.)			
12.	☐ Yes	☐ No	Do you follow Center for Disease Control Guidelines for Infection Control in Dental Health-Care Settings and observe all applicable laws and regulations related to the practice of dentistry including, but not limited to, those dealing with infection control and employee safety in the work place?
13.	☐ Yes	☐ No	Do you have current professional malpractice insurance coverage and agree to maintain continuous, uninterrupted coverage while a contracted dental provider for the Plan? Please not that under the terms of participation that you further agree to notify the Plan immediately of any policy cancellation, lapse in coverage, reduction in coverage maximum(s) or claims made.

I authorize the Plan to consult with professional liability carriers, and other persons or entities to obtain information concerning my professional qualifications including competence, ethics and other qualifications. I, the undersigned, hereby certify that the information requested by the Plan and provided herein, is truthful, correct and complete in all respects. I further understand that the intentional submission of false or misleading information or the withholding of relevant information shall result in immediate termination of the Dentist's Participation Agreement with Delta Dental.

I certify that all of the information herein is accurate and true to the best of my knowledge and agree to notify Delta Dental, in writing, of any changes in this document within 30 days of their occurrence.

Dentist Signature (no signature stamps) Date

Delta Dental of Arkansas Professional Relations Department, P.O. Box 15965, Little Rock, AR 72231
profrel@DDPAR.com • (501) 992-1710 • FAX: (501) 992-1867 attn: PR Department