



Capital Blue Cross Dental

Dentist application

Please include a copy of:

- Certificate of malpractice insurance coversheet (if available)
- Specialty training in board certificate and/or post graduate training – if specialist (optional)
- License
- DEA certification
- W-9 form

Please send completed application to:

Credentialing
c/o Dominion National
PO Box 211424
Eagan, MN 55121

Phone: 877.732.0008 Fax: 888.345.2040

Dentist information	Last name:			
	First name:		Middle name:	
Personal Social Security number - -	Date of birth mm/dd/yyyy	State(s) of license	License number(s)	<input type="checkbox"/> DMD <input type="checkbox"/> DDS
YOUR SSN AND DOB ARE REQUIRED. WE CANNOT ACCEPT YOUR FORM WITHOUT THESE ENTRIES				
Individual NPI (type I):		Practice NPI (type II) – if applicable:		
Medicaid ID (PROMISE ID in Pennsylvania):				
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have hospital privileges? If yes, complete the following: Hospital Name: _____ Phone: _____ Address: _____ City: _____ State: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Do you prescribe drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you an ADA member? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have special training? Specialty: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a Board Certified Specialist?				
Dental school:		Phone:	Graduation year:	
Specialty training institute:		Phone:	Completion year:	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say			Essential Community Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you are not a US Citizen, do you have authorization to work in the US? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Malpractice coverage	Please indicate insurance carrier and include coversheet (if available):			
	Insurance carrier or producer/agent: _____			
Mailing address: _____		City: _____	State: _____	ZIP Code: _____
Phone: _____		Amount: \$ _____ per occurrence \$ _____ aggregate		

Primary location	Practice name:						
	Start date at this practice: mm/yyyy						
Street address (no PO Box)			City		State	ZIP Code	
Tax ID # (TID) or Employer ID # (EID)			Practice phone number		Fax number		
Practice NPI				Wheelchair access? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email				Website			
Office hours e.g. 8:00–5:00	Monday -	Tuesday -	Wednesday -	Thursday -	Friday -	Saturday -	Sunday -
Number of associates		Language spoken other than English:					
PLEASE LIST ASSOCIATES BELOW. USE A SEPARATE SHEET IF NECESSARY.							
DENTIST APPLICATION MUST BE COMPLETED FOR ALL ASSOCIATES.							
Associate's name(s):							
1 st							
2 nd							

Additional location		Practice name:					
		Start date at this practice: mm/yyyy					
Street address (no PO Box)			City		State		ZIP Code
Tax ID # (TID) or Employer ID # (EID)			Practice phone number		Fax number		
Practice NPI				Wheelchair access? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email				Website			
Office hours e.g. 8:00–5:00	Monday –	Tuesday –	Wednesday –	Thursday –	Friday –	Saturday –	Sunday –
Number of associates		Language spoken other than English:					
PLEASE LIST ASSOCIATES BELOW. USE A SEPARATE SHEET IF NECESSARY.							
DENTIST APPLICATION MUST BE COMPLETED FOR ALL ASSOCIATES.							
Associate's name(s):							
1 st							
2 nd							

Work history		REQUIRED: List all your current and previous dentistry-related work and school experience for the LAST FIVE YEARS. Include residency or fellowship, as applicable.			
Previous practice name, experience, residency, etc.:		Location (city and state)		Start date mm/yyyy	End date mm/yyyy
Previous practice name, experience, residency, etc.:		Location (city and state)		Start date mm/yyyy	End date mm/yyyy
Previous practice name, experience, residency, etc.:		Location (city and state)		Start date mm/yyyy	End date mm/yyyy

- Yes** **No** **1.** In the past ten years, have you been involved in any malpractice suit or arbitration, or has any settlement been paid by you or on your behalf?
- IF YES,** please explain for each suit, arbitration or settlement (whether open or closed) all details including dates of incidents, filings, settlements; underlying circumstances; your role and legal status (defendant, co-defendant, other); subsequent events (including patient outcome); professional liability insurer involved; amounts paid; and current status.
- Yes** **No** **2.** Has your professional liability insurance ever been denied, suspended, cancelled, or not renewed?
- Yes** **No** **3.** Have you ever had any of the following items denied, revoked, suspended, not renewed, placed on probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?
- Yes** **No** State license
 - Yes** **No** DEA, CDS, or other applicable narcotic registration
 - Yes** **No** Hospital or healthcare facility staff membership or privileges
 - Yes** **No** Professional organization membership
 - Yes** **No** Medicaid or any other government program participation
 - Yes** **No** HMO, PPO, or other managed care plan
 - Yes** **No** Employment as a healthcare provider by a military service, hospital, HMO, or other healthcare organization
- Yes** **No** **4.** Do you have any physical or mental impairment or condition that, with or without accommodation, would make you unable to perform the essential functions of a practitioner in your area of practice or unable to perform such essential functions without a direct threat to the health and safety of others?
- Yes** **No** **5.** Considering the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that could pose a significant health and safety risk to your patients?
- Yes** **No** **6.** Within the past five years up to and including the present, have you ever had a chemical dependency or substance abuse problem that might adversely affect your ability to competently and safely perform essential functions of a practitioner in your area of practice.
- Yes** **No** **7.** Have you ever been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime?
- Yes** **No** **8.** Have you ever been subject to any peer-review type of action?

REQUIRED: PLEASE EXPLAIN ANY "NO" RESPONSE TO QUESTIONS 9 – 11 ON THE BACK OF THIS APPLICATION.

- Yes** **No** **9.** Does your office utilize proper infection control and barrier techniques?
- Yes** **No** **10.** Does your office comply with OSHA requirements?
- Yes** **No** **11.** Does your office have 24-hour emergency service or otherwise conscientiously make arrangements for emergency care, such as an answering service or machine with your home phone number, for your patients of record?
- Yes** **No** **12.** Is your office accepting new patients?

