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)	☐ DMD ☐ 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):

☐ Yes ☐ No Do you have hospital privileges? **If yes,** complete the following:
Hospital Name: _____ Phone: _____
Address: _____ City: _____ State: _____

☐ Yes ☐ No Do you prescribe drugs?
☐ Yes ☐ No Are you an ADA member?
☐ Yes ☐ No Do you have special training? **Specialty:** _____
☐ Yes ☐ No Are you a Board Certified Specialist?

Dental school:	Phone:	Graduation year:
Specialty training institute:	Phone:	Completion year:

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? ☐ Yes ☐ 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):

1st

2nd

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? ☐ Yes ☐ 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):

1st

2nd

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

Confidential questions

REQUIRED: PLEASE EXPLAIN ANY "YES" RESPONSE TO QUESTIONS 1 – 8 ON THE BACK OF THIS APPLICATION.

❑ **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?

Question explanation	**USE THIS SPACE, AND/OR A SEPARATE SHEET OF PAPER TO EXPLAIN ANY "YES" RESPONSE TO QUESTIONS 1 – 8 AND ANY "NO" RESPONSE TO QUESTIONS 9 – 11 FROM THE PREVIOUS PAGE.**

Authorization and releases REQUIRED

I attest to the accuracy and completeness of the information provided to Capital Blue Cross in this application and certify that all of the information is correct. I agree to immediately notify Capital Blue Cross of any changes to my licensure, liability insurance, or any other information provided to Capital Blue Cross. I understand that failure to immediately report information accurately and/or failure to immediately report changes could result in termination of my participation status.

I authorize and consent to Capital Blue Cross, its applicable affiliates ("Capital Blue Cross"), and its clients to whom information on this form may be released, their parent organizations, affiliates, subsidiaries, successors, employees, and vendors selected to perform credentialing services to obtain information from others, including, but not limited to, State licensing boards, certification boards, professional liability insurers (past and present), hospitals, substance abuse programs, healthcare-related employers, and other organizations concerned with my qualification, performance or conduct. I hereby request that all such individuals and institutions promptly reply to all requests for information from Capital Blue Cross, or their agents. I further authorize Capital Blue Cross and its agents to make inquiries of each of the foregoing concerning me and my professional practice.

I acknowledge that I have the right to review information obtained by Capital Blue Cross to support or evaluate my application. I further acknowledge that I have the right to correct erroneous information submitted by me or any outside source. I also have the right to be informed of the status of my application upon request.

I hereby (a) release from liability any and all individuals and organizations who provide information to Capital Blue Cross or their affiliates, agents, employees, or contractors, and (b) agree to hold the sources of such information harmless from any liability or claim arising from the release of this information, providing their acts were in good faith and without malice.

DENTIST'S NAME _____

DENTIST'S SIGNATURE _____ DATE mm/dd/yyyy _____

On behalf of Capital Blue Cross, Dominion Dental Services, Inc., d/b/a Dominion National, assists in the administration of the Capital Blue Cross Dental benefits. Dominion Dental is an independent company.

Capital Blue Cross Dental is issued by Capital Advantage Assurance Company®, a subsidiary of Capital Blue Cross. Independent licensees of the Blue Cross Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.