Application for Participation

Please complete and sign this form for each participating provider. (Please type or print legibly)

PROGRAMS: **DHMO (IL Only)** ❑ **PPO** ☒

Name ____
Last First Middle

Specialty ❑ **GD** ❑ **Endodontist** ❑ **Oral Surgeon** ❑ **Orthodontist** ❑ **Pediatric Dentist** ❑ **Periodontist**

Date of Birth ____/____/____ Social Security No. ______-____-______ Center No. *(if applicable)* __________

Dental License No. ______________________ State __________ Exp. Date __________

Federal Dea No. ______________________________ Exp. Date __________

State DEA No. ______________________________ Exp. Date __________

Medicaid No. *(if applicable)* ______________ NPI I ______________ NPI II ______________

Gender *(please circle)* **Male** **Female**

PLEASE ATTACH COPIES OF THE FOLLOWING DOCUMENTS TO THIS APPLICATION:

- Copy of license and current state registration(s)
- Copy of current DEA narcotics registration
- Copy of current state controlled substance certificate (if applicable)
- Copy of current malpractice face sheet
- Curriculum vitae/or professional work history document (most current five years)
- A completed W-9 Form for each unique tax identification number
- Copy of specialty certificate or American Board Certification (if applicable)

Completion of this application does not guarantee acceptance into the program.

Return completed application with signed contract to:

Dental Network of America – Attention Network Support
2 TransAm Plaza Drive
Oakbrook Terrace, Illinois 60181
FAX# 630-691-0290

Please retain a copy for your file.

PRACTICE LOCATIONS

PRIMARY OFFICE			OFFICE MANAGER
MAILING ADDRESS	CITY	STATE ZIP	COUNTY
OFFICE PHONE NUMBER ( )	FAX NUMBER ( )	EMAIL ADDRESS	FEDERAL TAX ID#

Regular Office Hours

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	–	–	–	–	–	–	–
PM	–	–	–	–	–	–	–

Do you agree to accept new patients under the plan?
YES ❑ NO ❑

Is your office accessible to the physically disabled?
YES ❑ NO ❑

Languages spoken in office____

2ND OFFICE			OFFICE MANAGER
MAILING ADDRESS	CITY	STATE ZIP	COUNTY
OFFICE PHONE NUMBER ( )	FAX NUMBER ( )	EMAIL ADDRESS	FEDERAL TAX ID#

Regular Office Hours

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	–	–	–	–	–	–	–
PM	–	–	–	–	–	–	–

Do you agree to accept new patients under the plan?
YES ❑ NO ❑

Is your office accessible to the physically disabled?
YES ❑ NO ❑

Languages spoken in office____

Attach additional pages if necessary.

BILLING INFORMATION

BILLING NAME			CONTACT PERSON *(if not office mgr.)*
MAILING ADDRESS	CITY	STATE ZIP	COUNTY
PHONE NUMBER ( )	FAX NUMBER ( )	FEDERAL TAX ID # *(if different from primary)*	

Are other members of your group applying for or currently participating? YES ❑ NO ❑	If you are applying as a member of a group, list all other members of your group: Name	Specialty

PROFESSIONAL EDUCATION

Dental Education

COMPLETE SCHOOL NAME					FROM *(month/year)*	TO *(month/year)*
MAILING ADDRESS	CITY	STATE	ZIP	COUNTY	DEGREE RECEIVED	
COMPLETE SCHOOL NAME					FROM *(month/year)*	TO *(month/year)*
MAILING ADDRESS	CITY	STATE	ZIP	COUNTY	DEGREE RECEIVED	

Residency

COMPLETE INSTITUTION NAME					FROM *(month/year)*	TO *(month/year)*
MAILING ADDRESS	CITY	STATE	ZIP	COUNTY	DEGREE RECEIVED	
CHAIR OF DEPT./CHIEF OF SERVICE	COMPLETED YES ❑ NO ❑	TYPE OF PROGRAM/SPECIALTY				

Fellowship(s)/Post Graduate Training ***(if currently in training, expected date of completion)***

COMPLETE INSTITUTION NAME					FROM *(month/year)*	TO *(month/year)*
MAILING ADDRESS	CITY	STATE	ZIP	COUNTY	DEGREE RECEIVED	
CHAIR OF DEPT./CHIEF OF SERVICE	COMPLETED YES ❑ NO ❑	TYPE OF PROGRAM/SPECIALTY				

Specialty Certification

SPECIALTY CERTIFICATION(S) - *(if certified)*			
DATE OF CERTIFICATION	DATE OF RE-CERTIFICATION	NAME OF BOARD AND SPECIALTY	EXPIRATION DATE *(if applicable)*

SPECIALTY CERTIFICATION IN PROCESS - ENCLOSE A COPY OF CONFIRMATION LETTER, IF AVAILABLE		
NAME OF BOARD	EXPECTED DATE OF CERTIFICATION	IF WRITTEN/ORAL COMPLETED ON SCHEDULE, GIVE DATES
SPECIALTY	EDUCATIONALLY QUALIFIED SPECIALIST YES ❑ NO ❑	DATE OF COMPLETION

WORK HISTORY *(Beginning with current practice)*

Please provide your professional work history for the past 5 years. Use additional pages if needed.

NAME OF ORGANIZATION OR OFFICE PRACTICE				MILITARY *(please circle)* **YES NO**	FROM *(month/year)*	TO *(month/year)*
MAILING ADDRESS	CITY	STATE	ZIP	PHONE NO.	POSITION	
NAME OF ORGANIZATION OR OFFICE PRACTICE				MILITARY *(please circle)* **YES NO**	FROM *(month/year)*	TO *(month/year)*
MAILING ADDRESS	CITY	STATE	ZIP	PHONE NO.	POSITION	
NAME OF ORGANIZATION OR OFFICE PRACTICE				MILITARY *(please circle)* **YES NO**	FROM *(month/year)*	TO *(month/year)*
MAILING ADDRESS	CITY	STATE	ZIP	PHONE NO.	POSITION	

HOSPITAL AFFILIATIONS *(if applicable)*

Primary Admitting Facility

COMPLETE INSTITUTION NAME					FROM *(month/year)*	TO *(month/year)*
MAILING ADDRESS	CITY	STATE	ZIP	COUNTY		SPECIALTY

Secondary Admitting Facility

COMPLETE INSTITUTION NAME					FROM *(month/year)*	TO *(month/year)*
MAILING ADDRESS	CITY	STATE	ZIP	COUNTY		SPECIALTY

PROFESSIONAL LIABILITY INSURANCE

Please submit a copy of your professional liability coverage 'face sheet' showing amounts and dates of coverage.

INSURANCE CARRIER				YEARS WITH CARRIER *From:* *To:*
ADDRESS	CITY	STATE	ZIP	PHONE NO.
POLICY NO.	COVERAGE AMOUNT			EXPIRATION DATE

PREVIOUS CARRIER *(if less than 5 years with current carrier)*				YEARS WITH CARRIER *From:* *To:*
ADDRESS	CITY	STATE	ZIP	PHONE NO.
POLICY NO.	COVERAGE AMOUNT			EXPIRATION DATE

PROFESSIONAL LIABILITY EXPERIENCE

Please provide detailed information on the attached Professional Liability Action Explanation Form.

DATE OF OCCURRENCE	AMOUNT PAID/IN RESERVE TO RESOLVE CLAIM	INSTITUTION INVOLVED *(i.e., hospital, etc.)*
NAME & ADDRESS OF INSURANCE CARRIER		CURRENT STATUS OF CLAIM *(open/closed/pending/resolved, etc.)*
DETAILS OF ALLEGATIONS:		

DATE OF OCCURRENCE	AMOUNT PAID/IN RESERVE TO RESOLVE CLAIM	INSTITUTION INVOLVED *(i.e., hospital, etc.)*
NAME & ADDRESS OF INSURANCE CARRIER		CURRENT STATUS OF CLAIM *(open/closed/pending/resolved, etc.)*
DETAILS OF ALLEGATIONS:		

DISCLOSURE QUESTIONS

IF YOU ANSWER "YES" TO ANY QUESTION, PLEASE PROVIDE DETAILS ON A SEPARATE PAGE.
INCLUDE A COPY OF ANY ORDER OR SETTLEMENT WHERE APPLICABLE.

1. ☐ Yes ☐ No Have you ever been disciplined by any State Board of Dental Examiners, or any Professional Conduct Board? Have you ever been reprimanded or fined by any state or federal agency that disciplines dentists?
2. ☐ Yes ☐ No Have you ever had any previous or pending challenges to, or voluntarily or involuntarily relinquished any professional license(s), narcotics registration, hospital membership or clinical privilege(s) as the result of any investigation or disciplinary action?
3. ☐ Yes ☐ No Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, suspended, reduced or not renewed? Have proceedings toward any of those ends ever been instituted?
4. ☐ Yes ☐ No Has your specialty board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended or reduced? Have any proceedings toward any of those ends been instituted?
5. ☐ Yes ☐ No Have you ever been denied membership, renewal of membership or been subject to any disciplinary action in any professional society or hospital?
6. ☐ Yes ☐ No Have your clinical privileges at any hospital or healthcare institution been limited, suspended, revoked, not renewed or subject to probationary or other disciplinary conditions?
7. ☐ Yes ☐ No Have you ever been reprimanded, censured, excluded, suspended or disqualified by Medicare, Medicaid or any other plan for which you provided services?
8. ☐ Yes ☐ No Have you ever been convicted of a felony or are you presently indicted for a felony?
9. ☐ Yes ☐ No Do you have or have you had a chemical dependency/substance abuse problem, treated or untreated? If "yes", provide details including a copy of the National Practitioner Data Bank report, if reported.
10. ☐ Yes ☐ No Have there ever been, or are there currently, any claims, settlements or judgements against you, or have you received any notice of "Intent to File?" If "yes", please provide detailed information on the enclosed Professional Liability Action Explanation Form.
11. ☐ Yes ☐ No Have you ever had any professional liability insurance coverage cancelled, declined or modified (i.e. reduced limits or restricted coverage)? Has any renewal ever been refused or have you voluntarily given up coverage?
12. ☐ Yes ☐ No Do you have a condition which would make you unable, with or without reasonable accommodation to perform the essential functions of a practitioner in your area of practice without posing a significant health or safety risk to your patients?

ATTESTATION AND RELEASE

The foregoing information is provided in confidence and is to be used solely for the purpose of credentialing, peer review and quality assurance processes in accordance with this authorization.

I authorize and release Dental Network of America (DNoA) to request information regarding my professional credentials and qualifications from educational facilities, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities and present and past employers listed on the foregoing pages. I further authorize those entities to submit any information requested by DNoA for the purpose of preparing a complete personal portfolio.

I understand and release DNoA to gather, verify and submit this information to those entities with whom I have or wish to establish contract relationship as a network provider.

I, the undersigned, hereby certify that the information provided in or attached to this application is accurate and complete. I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating dentist. I agree to inform DNoA in writing within 30 days if there is any change in the information provided as a result of any developments subsequent to my signing this application.

____
Name *(please print or type)*

______________________________ ______________
Signature *(original signature required)* Date

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