DENTAL PROVIDER CREDENTIALING APPLICATION

Please complete each section thoroughly by typing or clearing printing in blue or black ink.

Practitioner's Name:	**Date:**
Individual NPI:	**Tax ID:**

PLEASE INCLUDE THE FOLLOWING WITH THIS COMPLETED APPLICATION

- Copy of current DEA Registration (if applicable)
- Copy of current State Controlled Substance Registration/Certificate (if applicable)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and practitioner's name
- Copy of Board Certification Certificate(s) or other National Certification Certificate(s) (If applicable)
- Copy of Dental School Diploma
- Signature requirement on pages 8
- Copy of curriculum vitae (if applicable)
- Professional Liability Addendum
- W9

SEND COMPLETED APPLICATION ALONG WITH CREDENTIALS TO CASEY.GIMBEL@EZCOMPCARE.COM OR FAX 855-339-0612

CALL 855-939-2667 EXT 202 WITH ANY QUESTIONS

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

1. Applicant Information

Last Name (as shown on state license)	First Name	Middle Name	Maiden/Other Name	Suffix (e.g., Jr., Sr., etc.)

Professional Designation	Gender	Birth Date	Birthplace
☐ DDS ☐ DMD ☐ MD ☐ DO ☐ Other_____	Male ☐ Female ☐	_____/_____/_____	

Social Security #	Individual NPI	Are you a U.S Citizen?	Language(s) Spoken (other than English)
_____-_____-_____		Yes ☐ No ☐	

Area(s) of Specialty (please be specific and list any primary focus)

Specialty:	Sub-specialty:

Other Services Provided-Check all that apply

☐Conscious Sedation	☐Extractions	☐Root Canals	☐TMJ Disorders
☐IV Sedation	☐Dentures	☐Orthodontics	☐ Other (specify):

2. Practice Contact(s)

Office Manager	Phone	Fax	Email

Billing Manager	Phone	Fax	Email

Credentialing Manager	Phone	Fax	Email

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3. Office Practice Information:

If you have more than one office site or more than one billing address or entity, please make a photocopy of this section before completing it and provide information for each site or billing entity (i.e., multiple tax identifiers), as needed.

Group/Practice Name (must match W-9)			
Tax ID Number (must match W-9)		**Group NPI**	
Type of Practice	☐ Individual ☐ Partnership ☐ Group ☐ Corporation ☐ Hospital Based ☐ Teaching/Research	☐ Other (specify):	

Address (Building, Street, Suite #)	**City**

State	**Zip Code**	**County**

Telephone Number	**Fax Number**	**Answering Service/After-Hours Number**

E-Mail Address	**Dental Lab location**
	☐ In-House ☐ United States ☐ Other (specify):

Are you currently accepting new patients?	**Have you closed your practice to any plans or programs?**
☐ Yes ☐ By referral only ☐ No ☐ NA	☐ Yes ☐ No ☐ NA If Yes, please list:
Handicap Accessible?	**Public Transit Available?**
☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
Does the office have other services available for disabled? (TTY, ASI, Mental/physical impairments, etc.)	☐ Yes ☐ No ☐ NA If Yes, please list:

Office Hours

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

Does the office have the capability to bill electronically? ☐ Yes ☐ No If Yes, please list clearinghouse(s) used:

Remittance/Billing Information (if different than practice information)

Workers' Compensation Information

Do you accept Workers' Compensation Patients? (EZ Dental Care is a Work Comp Dental Network)	☐ Yes ☐ No
If yes, please provide the following information:	a. Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? ☐ Yes ☐ No b. Modified or alternative duty is actively evaluated for each Workers' Compensation claimant. ☐ Yes ☐ No c. Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible. ☐ Yes ☐ No d. Staff is available and willing to provide compensation representatives information regarding a claimant's care. ☐ Yes ☐ No

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4. Dental Professional Education:

Name of School	Degree Received	Graduation Date	
State	**Country**	**Phone # (if known)**	**Fax # (if known)**

5. State License(s): List all current professional licenses

State	License #	Issue Date	Expiration Date	Status (Please check)	Is/was license restricted?	Reason License is/was Inactive or Restricted
				☐ Active ☐ Inactive	☐ Yes ☐ No	
				☐ Active ☐ Inactive	☐ Yes ☐ No	

Have you completed the continuing education hours as required by your State Licensing Board during the past two (2) years OR the required CME/CEU hours (if applicable) from the State licensing board in which you are currently practicing?	☐ Yes ☐ No, if no provide written explanation

6. Certifications/Registrations

Federal DEA Certificate

Certificate #	Expiration Date	Unlimited?
		☐ Yes ☐ No If no, explain:
		☐ Yes ☐ N If no, explain:

State Controlled Substance Registration

Certificate #	Expiration Date	Unlimited?
		☐ Yes ☐ No If no, explain:

Other Certificate(s)/Formal Training
(Please check below if currently certified. Submit copy)

☐ Basic Life Support (BLS)	☐ Anesthesia Permit
☐ Advanced Cardiac Life Support (ACLS)	☐ Health Care Practitioner (Core C)
☐ Pediatric Advanced Life Support (PALS)	☐ Neonatal Resuscitation Program (NRP)
☐ Advanced Trauma Life Support (ATLS)	☐ Therapeutics Classification Number (Optometrists only)
☐ Neonatal Advanced Life Support (NALS)	☐ Other (please list below or on a separate sheet and include descriptions):

7. Work History/Experience:

List in chronological order (beginning with current) all current and previous professional work history, including Military Service. You must explain gaps greater than three (3) months

Start Date	End Date	Employer Name	City	State

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8. Professional Associations/Organizations

List the associations/organizations related to your profession in which you are a member. Please include dates of affiliations. Include faculty appointments.

Professional Association/Organization	Dates of Affiliation
	From: To:
Professional Association/Organization	**Dates of Affiliation**
	From: To:
Professional Association/Organization	**Dates of Affiliation**
	From: To:

9. Professional Liability Insurance Coverage Disclosure:

If the answer to any of these questions is yes, please provide a full explanation of the details of each and every matter The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, and the name and address of the attorney defending you, and all other relevant details. Include suits in which a judgment or settlement was made against a professional corporation of which you are/were a member, shareholder, or employee in any matter in which you were involved in the patient's care.

A. Has your professional liability insurance coverage ever been restricted, denied or terminated by action of the insurance company?	☐ No	☐ Yes
B. Has any (current or previous) professional liability insurance carrier excluded any specific procedures or specific area of practice (e.g., obstetrics, surgery, etc.) from your coverage?	☐ No	☐ Yes
C. During the time of your professional practice, have you had any professional liability claims, suits, settlements, or judgments filed against you or are any currently pending? If so, please complete, sign and date a Professional Liability Information Addendum page per each incident.	☐ No	☐ Yes
D. Have you ever practiced without professional liability coverage?	☐ No	☐ Yes

10. Business Interests:

A. Do you or your business entity own, operate, have an interest in, or participate in any medical enterprise or business?	☐ No	☐ Yes
B. Do you have a financial relationship with a hospital, clinical lab, nursing home, pharmacy, radiology lab, emergency room, or any other medical related organization?	☐ No	☐ Yes

11. Practice Disclosure Information:

If the answer to any question below is yes, please provide a full explanation of the details on a separate sheet and attach.

A. Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory agency?	☐ No	☐ Yes	
B. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand?	☐ No	☐ Yes	

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C. Have you ever been suspended, sanctioned, or otherwise restricted from participating or been the subject of an investigation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)?	☐ No	☐ Yes	
D. Has your narcotics (DEA) registration certificate (federal or state) ever been voluntarily or involuntarily relinquished, limited, suspended, not renewed, placed on probation, revoked, or challenged?	☐ No	☐ Yes	☐ NA
E. Have you ever been convicted of or plead no contest to any criminal (felony or misdemeanor) charges including a drug or alcohol-related offense or motor vehicle offenses, but not including minor traffic or parking violations? Are any such proceedings currently pending?	☐ No	☐ Yes	
F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken?	☐ No	☐ Yes	☐ NA
G. Have you ever been refused membership on the medical or allied health staff of any hospital or institution or been denied advancement in staff status?	☐ No	☐ Yes	☐ NA
H. Has your employment, medical staff status, appointment, reappointment, or clinical privileges, or scope of practice ever been voluntarily or involuntarily suspended, restricted, reduced, revoked, denied, relinquished, not been renewed or subjected to probationary conditions or limited at any hospital, managed care organization or other health care entity?	☐ No	☐ Yes	
I. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation, or otherwise sanctioned by any health care organization, including but not limited to, hospitals, HMOs, PPOs, IPAs, PHOs, professional associations or societies, professional standards review organization or peer review organizations, or any other health care facilities, based on professional competence?	☐ No	☐ Yes	
J. Have your ever withdrawn your application for appointment, reappointment or request for clinical privileges or resigned from the medical or allied health staff of a hospital, managed care organization, or other health care entity while under investigation or before a decision about your appointment or reappointment or clinical privileges was rendered by the governing board of any hospital, managed care organization or any other health care entity?	☐ No	☐ Yes	
K. Have you ever been allowed to resign your position or voluntarily relinquish specific clinical privileges rather than face any charge or investigation on the part of the medical staff of a hospital, managed care organization, or other health care entity?	☐ No	☐ Yes	
L. Are there currently pending adverse actions on your employment, medical staff appointment, reappointment, clinical privileges or scope of practice at any hospital, managed care organization, or other health care entity?	☐ No	☐ Yes	
M. Has any investigation (other than normal performance improvement reviews) involving your clinical practice, competence or professional conduct ever been initiated by any hospital, managed care organization, governmental agency, other health care entity, or branch of the armed forces?	☐ No	☐ Yes	
N. Has your request for any specific clinical privileges or scope of practice ever been denied (as a result of disciplinary action) or granted with stated limitations or conditions (aside from ordinary initial probationary requirements of proctorship)? Are such proceedings currently pending?	☐ No	☐ Yes	

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O. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society?	☐ No	☐ Yes	
P. Have you had any charges of unprofessional conduct brought against you?	☐ No	☐ Yes	
Q. Have you had any charges of fraud brought against you?	☐ No	☐ Yes	
R. Have you received any confirmed Quality Citations from a Peer Review Organization (PRO) in the last two (2) years? If you answered yes, on a separate sheet, indicate the address of the PRO that cited you, the circumstances of the citation and the number of points you were fined.	☐ No	☐ Yes	
S. Has any (current or previous) professional liability insurance carrier excluded any specific procedures or specific area of practice (e.g., obstetrics, surgery, etc.) from your coverage?	☐ No	☐ Yes	
T. Have any issues been reported to the National Practitioner Data Bank (NPDB)?	☐ No	☐ Yes	

12. Health Status

Note: Your application will be processed in the usual manner regardless of how you answer questions A and B. If you have answered "No" to question A or B, please explain completely on a separate sheet. If you are found to be qualified, a representative will contact you to determine what accommodations are necessary and feasible to allow you to practice safely.

A. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without a reasonable accommodation?	☐ Yes	☐ No
B. Are you able to perform these functions without significant risk of injury to yourself or others?	☐ Yes	☐ No
C. Do you illegally use drugs?	☐ Yes	☐ No
D. Have you used illegal drugs within the last two years?	☐ Yes	☐ No
E. Do you currently take any medications that may affect your ability to perform the clinical privileges or scope of practice requested competently and safely?	☐ Yes	☐ No

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ATTESTATION/AUTHORIZATION AND RELEASE OF INFORMATION

By submitting this attestation/authorization and release of information form in conjunction with the Provider Credentialing Application (PCA) and the Attestation/Authorization, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical/dental staff membership and/or participating status with the Health Care Entity indicated on the PCA for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and/or other qualifications.

2. I further understand and acknowledge that the Health Care Entity or designated Agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Health Care Entity as part of the verification and credentialing process.

3. I authorize all individuals, institutions, and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Health Care Entity(ies), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the requested clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5. I attest to the accuracy and completeness of the information provided. I understand and agree that any misstatements in or omissions from the PCA Attestation/Authorization and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.

6. I agree to exhaust all available procedures and remedies as outlined by in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Health Care Entity (ies) where I have membership and/or clinical privileges/participation.

7. I understand that completion and submission of the PCA Attestation/Authorization and Release of Information does not automatically grant me membership or clinical privileges/participating status with the Health Care Entity(ies) indicated on the PCA or Attestation/Authorization.

8. I further acknowledge that I have read and understand the foregoing Attestation/Authorization and Release of Information. A photocopy of this Attestation/Authorization and Release of Information shall be as effective as the original, and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation/authorization.

9. I release from liability any and all individuals and organizations who provide information to the credentialing entity in good faith and without malice concerning my professional qualifications and competence, and the credentialing entity, from liability for their acts performed and statements made relating but not limited to verifying, evaluating and acting upon my credentials and qualifications.

Print Name Here: _____

Signature: _____ Date: _____

NOTE: Through above signature, I hereby affirm that contents are current, accurate, and complete as of the signature date.

Modification to the wording or format of the PCA/Attestation/Authorization and Release of Information may invalidate an application.

EZ Dental Care, Inc. will treat this application and any information secured in connection therewith in strict confidence in accordance with the Entities' policies and/or Medical Staff Bylaws and preserve with all reasonable safeguards the privacy of the Applicant.

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

Professional Liability Information Addendum

(Photocopy this form for each case/action)

Please supply the following:

- **Information for each professional liability action you have had taken against you, with any actions or change of status, including those pending.**
- **Information for each settlement, or decision for the plaintiff that has occurred on your behalf.**

All information is held in strict confidence and used for credentialing and recredentialing purposes only. Failure to supply sufficient details may prevent your application from being approved. In addition to completion of this form, practitioner may also submit any additional supporting documentation.

☐ **Check here if entire section is not applicable to applicant.**
☐ **Check here if no professional liability actions/claims filed.**

1. Case Number	**2. Carrier Name**
3 Court	**4. Court address**
5. Name of Plaintiff	**6. Date of Incident**
7. Date Filed	**8. Date Closed**
9. What was/is your status in the case?	**10 What is the status of the case?**
☐ Primary Defendant ☐ Co-Defendant ☐ Other, please explain:	☐ Dropped ☐ Pending ☐ Settled Out of Court ☐ Found for Defendant ☐ Dismissed Without Payment ☐ Found for Plaintiff ☐ Under Appeal
11. Amount of Any Settlement or Award?	**12. Date of any Settlement or Award**
12. Attorney's name	**13. Attorney's address**

Please explain the following in detail. (If an item does not apply please check "N/A")

14. What was the alleged harm to the patient?		☐ N/A
15. What were you alleged to have done incorrectly or failed to do?		☐ N/A
16. Describe the patient's illness and related effects of the alleged harm.		☐ N/A
17. Describe any other details you believe are pertinent to the case.		☐ N/A
18. Identify any other parties named in the suit.		☐ N/A

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person ▶**	**Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*