



12121 North Corporate Parkway, Mequon, WI 53092
 (262) 241-7140 or (800) 417-7140
 Fax (262) 241-7401

*****INCOMPLETE APPLICATIONS WILL DELAY THE CREDENTIALING PROCESS*****

The following documents are **REQUIRED** for credentialing and consideration for privileges to participate in the DentaQuest, LLC (DentaQuest) network.

- ___ 1. A **COMPLETED** Provider Application that is signed and dated.
- ___ 2. A copy of **CURRENT** valid state license to practice dentistry.
- ___ 3. **National Provider Identifier Number**
- ___ 4. A copy of **CURRENT** professional liability insurance policy that indicates carrier name, policy number, expiration dates and policy limits.
- ___ 5. A copy of professional liability claims history (if applicable).

PLEASE INDICATE:

- New Provider, New Location
- New Provider, Existing Location
- Adding Additional Location
- Other

Please add _____ to our current contract under _____
 (Provider Name) (Entity Name)
 with Tax ID # _____.

Name of Applicant		
Last Name	First Name	Middle Name
Specialty		
Office Contact for Credentialing Information		

PLEASE REMEMBER:

- **PROVIDER CANNOT BEGIN TO TREAT MEMBERS UNTIL FINAL APPROVAL FROM DENTAQUEST IS RECEIVED**

DentaQuest Credentialing Process

Credentialing is the process of verifying credentials (i.e. training, licensing, hospital affiliations) of potential providers by primary sources. DentaQuest takes pride in its network of providers and is proud to say that all providers are credentialed following the guidelines of the National Committee for Quality Assurance (NCQA) to ensure our members that they are receiving the best quality care possible. Using NCQA guidelines for credentialing will ensure an organization that the providers affiliated with their panel are the best in the dental field.

PROVIDER APPLICATION

GENERAL INFORMATION

Last Name		First Name		Middle Initial	Date of Birth (MM/DD/YY)
Provider Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Provider Race/Ethnicity: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White			Email Address:	
Primary Office Name	Office Contact	()	()	Telephone Number	Fax Number
Primary Office Address	City	State	Zip Code	County	
Secondary Office Name	Office Contact	()	()	Telephone Number	Fax Number
Secondary Office Address	City	State	Zip Code	County	

BILLING INFORMATION

Federal Tax Identification Name (Name to which payments should be made)			Federal Tax Identification Number		
Billing Office Address	City	State	Zip Code		
Billing Office Contact Name / Title	() Telephone Number	() Fax Number	License Plate Number (Mobile Units Only)		
If you practice at more than one location, do you require separate checks for each location? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate payment information for secondary office below.					
Federal Tax Identification Name (Name to which payments should be made)			Federal Tax Identification Number		
Billing Office Address	City	State	Zip Code		
Billing Office Contact Name / Title	() Telephone Number	() Fax Number	License Plate Number (Mobile Units Only)		

AMERICAN BOARD CERTIFICATION

Specialty Board(s) by which you are certified			
Name	Date Certified	Expiration Date	Recertification Date

PRACTICE INFORMATION

Practice Type (check one) <input type="checkbox"/> Adults Only <input type="checkbox"/> Children Only <input type="checkbox"/> Adults & Children If you see children, minimum age _____			
What percentage of your patients are treated in an outpatient operating room setting? _____ %			
List all Hospitals at which you have admitting privileges:			
Hospital Name	Address	City	State
Hospital Name	Address	City	State
Hospital Name	Address	City	State

OFFICE INFORMATION

Office Hours Primary Location	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Office Hours Secondary Location	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you have coverage after normal business hours? _____ If yes, please list contact information: _____

Languages spoken at office (check all that apply)
 English Spanish Arabic Chinese French German Hmong Hindi Laotian Philippine Vietnamese Other _____

Is your office capable of handling hearing or visually impaired individuals? Yes No Is your office handicapped accessible? Yes No
 Number of treatment chairs: _____ Type of x-ray machine: Conventional Panorex

Does your office have a personal computer? Yes No

LICENSE/IDENTIFICATION NUMBERS

Social Security Number	Professional License Number/State/Exp Date
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DEA Number _____ Expiration Date _____

Please Check the Schedules that apply on your DEA certificate:
 2 2N 3 3N 4 5 All Schedules If any of the schedules are missing, please indicate: Provider's Choice Other, please explain:

Do you administer Intravenous or Conscious Sedation? Yes No If yes, please attach a copy of your current, valid anesthesia license.

Anesthesia License Number _____ State _____ Expiration Date _____

NPI INFORMATION

Please check box if Sole Proprietor. ALL providers MUST complete NPI information.

Individual NPI Information

NPI Number	INDIVIDUAL NPI Type	NPI Effective Date	DentaQuest's Provider ID	Taxonomy Code
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Group / Organization NPI Information (REQUIRED unless you are a Sole Proprietor)

NPI Number	GROUP NPI Type	NPI Effective Date	DentaQuest's Provider ID	Taxonomy Code
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Sub-Part Information (Optional – may be necessary to identify multiple locations.)

NPI Number	SUB-PART NPI Type	NPI Effective Date	DentaQuest's Provider ID	Taxonomy Code
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NPI Number	SUB-PART NPI Type	NPI Effective Date	DentaQuest's Provider ID	Taxonomy Code
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NPI Number	SUB-PART NPI Type	NPI Effective Date	DentaQuest's Provider ID	Taxonomy Code
NPI Number	SUB-PART NPI Type	NPI Effective Date	DentaQuest's Provider ID	Taxonomy Code

PROFESSIONAL EMPLOYMENT HISTORY

Chronologically list all present and previous work history related to your professional employment within the past five (5) years. Please provide a written explanation of any gaps grater than 6 months.

What was your start date at primary location? _____ / _____ / _____ (day / month / year)

Hire Date (MM/YY)	Termination Date (MM/YY)	Employer	Location Address	Reason for Leaving

EDUCATION / TRAINING

Professional School Name	City/State	Degree(s)	Date Received
Internship / Residency	City / State	Specialty	Beginning / Ending Dates
Institution Name	City / State	Specialty	Beginning / Ending Dates

PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE

List **ALL** insurance carriers for the past 5 years. Attach additional sheets if necessary.

Name of current Carrier		Mailing Address		
Phone #	Fax #	Policy #	Effective Date	Expiration Date
Amounts of Coverage: Occurrence/Claim \$ _____		Aggregate \$ _____		
Previous Carrier		Mailing Address		
Phone #	Fax #	Policy #	Effective Date	Expiration Date
Amounts of Coverage: Occurrence/Claim \$ _____		Aggregate \$ _____		
Previous Carrier		Mailing Address		
Phone #	Fax #	Policy #	Effective Date	Expiration Date
Amounts of Coverage: Occurrence/Claim \$ _____		Aggregate \$ _____		

For Mobile Dental Clinics or Portable Dental Operations Only:

Is your mobile dental clinic or portable dental operation operated by a federal, state or local governmental agency? ___Yes ___ No

Does your mobile dental clinic or portable dental operation provide dental treatment without charge to patients or to any third party payer and which is not provided on a regular basis (recurring at fixed or uniform intervals)? ___Yes ___ No

If the answer to either of the questions above is no, is your mobile dental clinic or portable dental operation registered to legally operate in Virginia? ___Yes ___ No

(Note: Proof of registration must be included with this application)

QUESTIONNAIRE

Please mark with an **X** under the yes/no columns for each question. If you answer **YES** to any of the following questions, please provide us with a detailed explanation in the space provided below.

YES **NO**

- 1. Has your Dental License been limited, suspended, denied, revoked, restricted, subject to probationary conditions, or have proceedings been instituted against you?

- 2. Have you voluntarily relinquished, reduced, restricted, or otherwise limited your dental license in any jurisdiction?

- 3. Have you been reprimanded or disciplined by any State or Commonwealth Department of Regulation and Licensure of the Dental Examining Board?

- 4. Has your participation for receiving payment under the Medical Assistance , Medicaid, or Medicare program been suspended or limited or have you voluntarily terminated your participation?

- 5. Have you been convicted of any criminal offenses, pending or otherwise, other than a minor traffic violation?

- 6. Have you had a judgment made against you for alleged malpractice, negligence, or related matters? Are any cases pending?

- 7. Have you had any judgments made against you in a professional liability case or has your liability insurer placed any conditions or restrictions on your coverage or ability to attain coverage?

- 8. Have any litigation settlements been made on your behalf?

- 9. Are you, or have you been, under the treatment for the use of narcotics, barbiturates, alcohol, or other drugs?

- 10. Do you presently have any physical or mental condition that would adversely affect your ability to provide high quality professional services? Are there any accommodations that need to be considered? Please list accommodations below.

- 11. Has your participation with a managed care organization, other health care organization or hospital privileges been suspended, limited, or terminated?

- 12. Has your Drug Enforcement Agency (DEA) registration been denied, revoked, suspended, not renewed or have you voluntarily surrendered, reduced, or limited your DEA registration?
(If you do not have a DEA or your DEA does not list all schedules 2, 2N, 3, 3N, 4, and 5; please provide an explanation)

- 13. Are you currently using illegal drugs?

- 14. Have you verified through the Excluded Parties Listing Service that none of the employees working in your practice(s) are excluded from participating in Medicaid Programs?

Yes NO Not Applicable, I am not the owner of the Dental Practice

(If you need additional space, please attach separate sheets)

Name: (Please Print) _____

CERTIFICATION, STATEMENTS, AND SIGNATURE

I hereby acknowledge that the information provided in this application is material to the determination by DENTAQUEST whether or not to execute an agreement with me. I hereby represent and warrant that all information provided herein is true, correct and complete to the best of my knowledge, and I agree to notify DENTAQUEST in the event an error is discovered or when new events occur which alter the validity of any response herein. I hereby authorize DENTAQUEST to consult with individuals or institutions with which I have been associated and with others, including but not limited to past and present malpractice carriers, educational institutions, and state licensing boards, who may have information bearing on my professional competence, character and ethical qualifications and authorize the release of any such written or oral verification as needed by DENTAQUEST. I hereby release from liability for any such entity, institution or organization that provides information as part of the application process.

I certify that:

- * All parties of material interest have been identified and include no persons or entities with a potential for profit from self-referral,
- * All services are provided by and under the “on Premise” supervision of a licensed dentist,
- * The above information is complete, correct and true to the best of my knowledge,
- * **My malpractice information is current at the time of the application and the limits are at the minimum amounts required by the State and DentaQuest.**

Signed by: _____
Principal

Date: _____

Please print name: _____

All applications are subject to review and approval by DENTAQUEST.

All information contained in a credentialing file will be held in strict confidence, and available for review by only duly authorized employees of DentaQuest Dental USA, LLC, DMAS, and/or third party review organizations (i.e. NCQA, etc.) Practitioner has the right to obtain a copy of their credentialing file, by submitting a written, signed request to the Supervisor of Credentialing at the corporate headquarters for DentaQuest Dental USA, LLC. Any corrections, additions, or clarifications to these files must be submitted in writing to the Supervisor of Credentialing. The practitioner has the right, upon request, to be informed of the status of their credentialing or re-credentialing application via phone, fax, or mail. If the Credentialing Committee recommends the acceptance of an application with restrictions, denial of an application, or discipline or termination of a practitioner, written notification will be issued within 30 days of that decision. The practitioner then has 30 days from the date of the notice to submit a written appeal of that decision. Appeals should be addressed to the Credentialing Committee, DentaQuest Dental USA, LLC and sent to DentaQuest’s corporate address.

In the event that a dentist’s application for participation is rejected or limited for reasons pertaining to the applicant’s professional conduct or competence, DentaQuest is required to submit a report to DMAS. DMAS will submit a report to the National Practitioner Data Bank and the state licensing board as required by law.

FOR DENTAQUEST USE ONLY

Initial Entry By: _____ Date: _____

Final Entry By: _____ Date: _____

Commonwealth of Virginia
Department of Medical Assistance Services
Smiles for Children Program
Participation Agreement

If re-enrolling, enter NPI here→

This is to certify:

PAYMENT/CORRESPONDENCE ADDRESS

PHYSICAL ADDRESS
(REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS)

INDIVIDUAL NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____, _____ agrees to participate in the Smiles for Children Program, the Department of Medical Assistance Services (DMAS), the legally designated State Agency for the administration of Medicaid, FAMIS and FAMIS Plus.

1. The provider is authorized to practice under the laws of the state in which he is licensed and practicing and is not as a matter of state or federal law disqualified from participating in the Program.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) DMAS.
3. The provider agrees to keep such records as DMAS determines necessary. The provider will furnish DMAS on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized DMAS representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of DMAS for the submission of claims.
5. Payment made by DMAS constitutes full payment except for patient pay amounts determined by DMAS, and the provider agrees not to submit additional charges to the recipient for services covered under DMAS. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to DMAS.
7. Payment by DMAS at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider will reimburse DMAS upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.
9. This agreement may be terminated at will on thirty days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Smiles for Children Program.
10. All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. This agreement shall commence on _____. Your continued participation in the Smiles for Children Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Smiles for Children Participation Agreement.

For Provider of Services:

Original Signature of Provider Date

Provider Specialty

City OR County of

Board License Number (Area Code) Telephone Number

IRS Identification Number (Required) UPIN

Medicare Carrier and Vendor Number

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to managed care organizations that contract with the State Medicaid Agency: 1) the identity of all owners with a control interest of 5% percent or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. **Please attach a separate sheet if necessary.**

Check one that most closely describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity
Name of Individual, Group Practice or Disclosing Entity:
DBA Name:
Address:
Federal Tax Identification Number:

I am an employee of the Group Practice and do not have a controlling interest of 5% or greater in the Group Practice _____
Yes

If Yes, go to the next page of the application to sign and date the Disclosure section.

List the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest of 5 percent or greater in this provider entity.			
List the name, Tax Identification Number (TIN) and business address of each organization, corporation or entity having an ownership or control interest of 5 percent or greater . Please attach a separate sheet if necessary. (42 CFR 455.104)			
Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)	
Names	Relationship

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% percent or more? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% percent or more . (42 CFR 455.104)			
Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare or Title XX program? Yes No (verify through HHS-OIG Web site)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than \$25,000 or any significant business transactions with any subcontractors? Yes No

If yes, list the ownership of any subcontractor with whom this provider **has had business transactions totaling more than \$25,000** during the previous twelve 12-month period; **and any significant business transactions** between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past five-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information¹) as a Disclosing Entity? Yes No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN) and percent of interest.

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate or incomplete data may result in a denial of participation.

Signature

Title (or indicate if authorized Agent)

Name (please print)

Date