

Credentialing Application

CompBenefits is interested in creating a business relationship with qualified professionals. Each dentist that will provide services to CompBenefits' members must complete all sections of this application. Please note that CompBenefits' goal is for each Participating Dentist to achieve a level of credentialing that meets the comprehensive standards set forth by the National Committee for Quality Assurance (NCQA). These standards mandate that the entire credentialing process be completed within a 120 day period. To facilitate the timely completion of this process, please follow the instructions below.

1. A Credentialing Application **must be completed** by all dentists treating CompBenefits members.
2. Leave **no blank spaces** (if a question does not apply – please mark the space N/A)
3. Provide **clear copies** of all the required documents listed below.

These requirements apply to dentists in all states *except* Texas:

(NOTE: Florida providers are required to submit a copy of their malpractice face sheet in addition to the requirements below.)

- Current Dental License
- Current DEA Certificate and/or State Controlled Substance Certificate (where applicable)
- Specialty Certificate (if applicable)
- W-9 Form

These requirements *apply* only to Texas dentists:

- Current Dental License
- Current DEA Certificate
- Current DPS Permit
- Current Professional Liability Insurance (indicating levels of coverage and effective dates)
- Radiology Registration Certificate
- W-9 Form

Thank you for your interest in CompBenefits. Should you have any questions, please feel free to contact our Professional Services department at (800) 382-3979, Monday – Friday, 8am – 6pm EST.

Date Received in Professional Services: _____

Credentialing Application

Type or print clearly. Fill in all spaces. If you have no answer, write "N/A", "None" or "No", as appropriate. Give complete answers to all questions and attach required documentation, as designated. If more space is needed for answers, please attach additional sheets.

Personal Information:

Practice Name:	Tax ID #:	National Provider Identifier#: Ind./Group # (Circle One)		
Last Name:	First Name:	M.I.	DDS, DMD	Office Telephone (Area Code) + Ext.:
Date of Birth (Required):		Social Security Number (Required):		
Office Street Address:		Suite Number:		
P.O. Box # (if applicable) City, State, Zip Code:			Office Email Address:	
Office Mailing Address (if different from above):			Office Fax Number (Area Code):	
Mailing City, State, Zip Code:		Alternate Office Telephone (Area Code) + Ext.:		

Credentials:

Attach all required documents:

State Dental License:	License Number:	License Exp. Date:
*DEA Registration Number:	DEA Exp. Date:	
DPS/CDS Registration Number:	DPS/CDS Registration Exp. Date:	

* Check if Applicable: _____ I don't have and never had a Federal DEA registration number.

Professional Liability Insurance:

Provide us with complete information regarding your professional liability insurance carrier.

Professional Liability Insurance Company:		
Professional Liability Policy #:	Professional Liability Limits: (Each Claim)	(Aggregate Claim)
Professional Liability Exp. Date:		

Education:

(Please do not abbreviate School Name)

Dental School:	Year Graduated:
Specialty School:	Year Graduated:
Residency Program (if applicable):	Year Graduated:

Specialty Type:(Check One)

General Dentist: _____ Endodontist: _____ Oral Surgeon: _____ Orthodontist: _____
Pediatric Dentist: _____ Periodontist: _____ Prosthodontist: _____

Board Eligible: Yes: _____	No: _____	Year Eligible: _____
Board Certified: Yes: _____	No: _____	Year Eligible: _____

Hospital Affiliations:(If applicable)

Hospital Name:	Date of Affiliation: (From – To)
Street Address:	Hospital Telephone Number (Area Code):
City, State, Zip Code:	Membership Classification:
Hospital Name:	Date of Affiliation: (From – To)
Street Address:	Hospital Telephone Number (Area Code):
City, State, Zip Code:	Membership Classification:

History of Professional Practice:

Provide chronological work history for at least the past five years to present. Provide an explanation for any gaps greater than six months.

Name Of Current Practice:	From:	To:
	Description:	
Name Of Immediately Preceding Practice or Activity:	From:	To:
	Description:	
Name of Immediately Preceding Practice or Activity:	From:	To:
	Description:	

CompBenefits Corporation captures important information to assist us in working with small businesses or historically under-utilized businesses. If your practice qualifies as a small business or historically under-utilized business, please check the applicable categories:

- _____ **Small business**
- _____ **Service-disabled veteran-owned small business**
- _____ **Veteran-owned small business**
- _____ **HUBZone small business**
- _____ **Small disadvantaged business**
- _____ **Female-owned small business**

Release Authorization

PLEASE READ AND UNDERSTAND THE FOLLOWING AGREEMENT BEFORE SIGNING THIS INQUIRY

I certify that all the information submitted by me in this inquiry is true to the best of my knowledge and belief.

I understand that any misstatement in or omission from this inquiry constitutes cause for denial of privileges to provide contract services to CompBenefits Corporation and its subsidiaries, any affiliated Managed Care Organizations or their agents.

I authorize CompBenefits Corporation and its subsidiaries, an affiliated Managed Care Organizations or their agents, to contact and consult with administrators, administrative staff, and medical staff hospitals, institutions, and health-care or other organizations with which I am or have been associated, which may contain information relating to my professional and ethical qualifications, competence, character, and personality.

I release from liability all individuals and organizations which provide information to CompBenefits Corporation or to its subsidiaries, any affiliated Managed Care Organizations or their agents, in good faith in connection with evaluation my inquiry and materials I have authorized them to request and inspect.

I release CompBenefits Corporation as well as its present, former and future parents, subsidiaries, divisions, merged and affiliated companies and their successors and assigns, together with each and every one of its directors, officers, employees, contractors, and agents, second party, any affiliated Managed Care Organizations or their agents, administrators and staff from liability for disclosing information obtained in the course of their efforts to evaluate my inquiry and qualifications for employment and privileges in the future. I agree that photocopies of this signed authorization will be acceptable as an original signature.

I understand that CompBenefits Corporation and its subsidiaries, any affiliated Managed Care Organizations or their agents, will rely upon the information given on this inquiry form during the processing of my request to perform contract services. A photocopy of this permission will serve as the original.

Name (Typed or Printed)

Signature (Required)

(Date Signed)

Attestation Page:

1. Has your license to practice dentistry in any jurisdiction ever been denied, revoked, suspended, restricted, not renewed or any actions pending; or have you been subject to disciplinary review, sanctioned, placed on probation, or privileges limited?

If "Yes" response, a detailed explanation is required. Yes ___ No ___

2. Has your professional liability insurance coverage ever been denied, revoked, suspended or not renewed, or is such action pending?

If "Yes" response, a detailed explanation is required. Yes ___ No ___

3. Has your Federal DEA Registration and/or DPS State Controlled Substances Permit ever been denied, revoked, suspended, restricted, or is such action pending?

If "Yes" response, a detailed explanation is required. Yes ___ No ___

4. Have you been disciplined, denied membership or membership renewal, canceled, suspended, subject to disciplinary review in any state, federal or any government agency (i.e. Medicare, Medicaid)?

If "Yes" response, a detailed explanation is required. Yes ___ No ___

5. Have your hospital privileges with any hospital or institution been denied, suspended, not renewed, subject to disciplinary review, or is such action pending?

If "Yes" response, a detailed explanation is required. Yes ___ No ___

6. Have you ever been disciplined, denied membership, membership renewal, or are such actions pending by a dental society or other professional organization?

If "Yes" response, a detailed explanation is required. Yes ___ No ___

7. Do you presently have a physical or mental condition that would prevent you from performing any procedure within the scope of your dental duties as a health care provider, with or without reasonable accommodations required by the American With Disabilities Act, or that would jeopardize the health and/or safety of the patient?

If "Yes" response, a detailed explanation is required. Yes ___ No ___

8. Have you in the last 2 years or do you currently use illicit drugs or engage in improper use of prescription drugs?

If "Yes" response, a detailed explanation is required. Yes ___ No ___

9. Have you ever been convicted of a felony or misdemeanor, or pleaded "nolo contendere" or do you have current charges pending against you?

If "Yes" response, a detailed explanation is required. Yes ___ NO ___

10. Have you ever been or currently involved or named in a professional liability suit, settlement or judgement? If yes, please provide a detailed description of your involvement and the amount of the settlement.

If "Yes" response, a detailed explanation is required. Yes ___ No ___

11. Is your malpractice insurance coverage current? Yes ___ No ___

12. Is your malpractice insurance equal to or greater than (\$100,000) per claim and (\$300,000) in aggregate? Yes ___ No ___

13. Do you currently employ an Office Manager? Yes ___ No ___

14. Do you currently employ an accountant? Yes ___ No ___

15. How long has your practice been in business? _____ years _____ months

16. Has your practice, or any practice you have owned in the past, ever filed for protection under bankruptcy laws?

If "Yes" response, a detailed explanation is required. Yes ___ No ___

17. **For Texas DHMO providers only** – Are you willing to accept new CompBenefits DHMO members?

Yes ___ No ___

I authorize CompBenefits and its subsidiaries and any affiliated credentialing verification organizations or their agents to consult with professional liability carriers, and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics and other qualifications. I, the undersigned, hereby certify that the information requested by CompBenefits Corporation and its' subsidiaries, is truthful, correct and complete in all respects, and further understand the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating dentist with CompBenefits and its' subsidiaries. The undersigned hereby agrees to notify CompBenefits and its' subsidiaries and any affiliated credentialing verification organizations or their agents of any changes in the above information.

Dentist's Signature (**No Signature Stamps**)

Date Signed