EmblemHealth®

DENTAL PROVIDER APPLICATION

EmblemHealth®

DENTAL APPLICATION

I am applying to participate in the following EmblemHealth dental network(s):

☐ Preferred ☐ Preferred Plus

Please use the checklist below to ensure we have all the information we need to process your application efficiently.

BE SURE THAT:

☐ * **Each doctor** who will be treating patients in the EmblemHealth Dental program has completed an Application form and that **all sections** of the Application form are filled out completely.

☐ * **Your personal SSN and date of birth** are included. This is required even if you submit claims under a different number.

☐ * **The ID number you use to submit claims** (i.e., your Social Security Number or Tax Identification Number) is included for each location.

☐ * **Thorough explanations** are given for any "YES" answers to Questions 1-8 and any "NO" answers to Questions 9-11.

☐ * **Your signature** appears in two places:

- ✓ on the Application form; and
- ✓ on the EmblemHealth Dental Preferred and/or Preferred Plus Individual Dentist Contract and/or Group Dental Contract.

☐ * **You have included** a copy of your

- ✓ **Professional Liability Insurance** (not general) page(s), showing name and address of carrier, individuals covered, expiration date and liability limits.
- ✓ **Current Federal DEA Certificate** and
- ✓ **Controlled Dangerous Substance Certificate (CDS)**, if you prescribe.

☐ * **Form W-9**

*** Required**

EmblemHealth, Dental Network Development, P.O. Box 12365, Albany, NY 12214-5555

Fax: 1-212-615-4953 (In NYC, Long Island, New Jersey, Westchester County or Rockland County)
Fax: 1-518-446-0185 (In Upstate New York and Other States)
Email: dentalproviders@emblemhealth.com

Dentist Information

Last Name	First Name	Middle Name

Personal Social Security Number	Date of Birth	State(s) of License *Please attach copies.*	License Number(s)	DMD or DDS *Circle one.*
- -	/ /			

Personal NPI #

Gender: ☐ Male ☐ Female

YOUR SSN AND DOB ARE REQUIRED. WE CANNOT ACCEPT YOUR APPLICATION WITHOUT THIS INFORMATION.

☐ Yes ☐ No Do you have hospital privileges? **If Yes, complete the following:**

Hospital Name: _____ Phone: _____

Address: _____ City: _____ State: _____

☐ Yes ☐ No Do you prescribe drugs? **If Yes, attach a copy of DEA and CDS, as applicable.**

☐ Yes ☐ No Have you registered with CMS as a Medicare Part D prescriber?

☐ Yes ☐ No Are you an ADA member?

☐ Yes ☐ No Do you have Specialty training? **Specialty:** _____

☐ Yes ☐ No Are you a Board Certified Specialist?

If you are an oral surgeon, please provide a copy of your anesthesia license.

Do not write in this box - for office use only

Dental School	Phone	Graduation Year

Specialty Training Institute	Phone	Completion Year

Malpractice Coverage

Please attach copies.

Current Carrier: _____

Policy Number: _____ Coverage Dates: Start: ____/____/_____ Expiration: ____/____/_____

Professional Liability Limits: _____

IMPORTANT: PLEASE LIST ALL CARRIERS FOR THE LAST 5 YEARS.

Previous Carrier	Policy #	Coverage Start Date	Coverage End Date
		/ /	/ /
Previous Carrier	Policy #	Coverage Start Date	Coverage End Date
		/ /	/ /

Primary Location

Type of Practice: ☐ Individual ☐ Group ☐ Other Practice NPI #: _____

Practice Name: _____

Start Date at This Practice: ____/____/_____

Street Address (no P.O. Box)	City	County	State	ZIP Code

Tax ID # (TIN) or Employer ID # (EIN)	Practice Phone Number	Wheelchair Access? ☐ Yes ☐ No

Practice Fax Number	E-mail Address

Office Hours Ex: 8:00 to 5:00	Monday : to :	Tuesday : to :	Wednesday : to :	Thursday : to :	Friday : to :	Saturday : to :	Sunday : to :

Number of Associates	Languages Spoken Other Than English

PLEASE LIST ASSOCIATES BELOW. USE A SEPARATE SHEET AS NECESSARY.

Associate's Name	Tax ID # (TIN) or Employer ID # (EIN)	Personal Social Security Number
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Additional Location

Type of Practice: ☐ Individual ☐ Group ☐ Other Practice NPI #: _____

Practice Name: _____

Start Date at This Practice: ____/____/_____

Street Address (no P.O. Box)	City	County	State	ZIP Code

Tax ID # (TIN) or Employer ID # (EIN)	Practice Phone Number	Wheelchair Access? ☐ Yes ☐ No

Practice Fax Number	E-mail Address

Office Hours Ex: 8:00 to 5:00	Monday : to :	Tuesday : to :	Wednesday : to :	Thursday : to :	Friday : to :	Saturday : to :	Sunday : to :

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Work History

REQUIRED: List all your current and previous dentistry-related work and school experience for the LAST 5 YEARS. Include residency or fellowship, as applicable. If there are any gaps in your work history greater than 6 months, please provide an explanation under "Question Explanation" on the next page.

Previous Practice Name, Experience, Residency, etc.	Location (City and State)	Start Date / Month Year	End Date / Month Year
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Previous Practice Name, Experience, Residency, etc.	Location (City and State)	Start Date / Month Year	End Date / Month Year

Confidential Questions

REQUIRED: Please explain any "yes" answers to questions 1-8 on the back of this application.

☐ Yes ☐ No 1. Are you now or have you ever been involved in any malpractice suit or arbitration, or has any settlement ever been paid by you or paid on your behalf?

If YES, please explain for each suit, arbitration or settlement (whether open or closed) all details, including dates of incidents, filings and settlements; underlying circumstances; your role and legal status (defendant, codefendant, 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, canceled 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 other health care facility staff membership or privileges
- ☐ Yes ☐ No Professional organization membership
- ☐ Yes ☐ No Medicaid or other government program participation
- ☐ Yes ☐ No HMO, PPO or other managed care plan
- ☐ Yes ☐ No Employment as a health care provider by a military service, hospital, HMO or other health care 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 or 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 the 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" answers 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?

Question Explanation

USE THIS SPACE OR A SEPARATE SHEET TO EXPLAIN ANY "YES" ANSWERS TO QUESTIONS 1-8 AND ANY "NO" ANSWERS TO QUESTIONS 9-11 FROM THE PREVIOUS PAGE.

Authorization and Releases

REQUIRED

I authorize EmblemHealth to obtain information from others, including state licensing authorities, certification boards, professional liability insurance carriers (including claim histories and loss reports), hospitals, substance-abuse programs and health care-related employers about my qualifications, including, without limitation, my professional competence and conduct. I authorize EmblemHealth and its clients to release information on this form to their parent organizations, affiliates, subsidiaries, successors, employees and agents.

I consent to the release to EmblemHealth any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged. I release any persons or entities providing information to or evaluating the information received or provided on this form from any and all liability, providing their acts were performed in good faith and without malice.

I understand I have the burden of providing adequate information to demonstrate my qualifications. I understand and agree that any misstatement or material omission on this form may constitute grounds for rejection of my application or dismissal as a member or participating provider with EmblemHealth client-sponsored networks. I understand and agree that it is my obligation to immediately notify EmblemHealth if any material changes occur in the information I have provided on this form. I understand that statements written on this form will be considered statements made by me, even if prepared by an employee, agent or representative.

I attest that the information contained on this form is correct and complete.

Dentist's Name _____

Please print

Dentist's Signature _____ Date _____

Original signature only - NO STAMPS

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