NORTHEAST DELTA DENTAL
RE-CREDENTIALING CHECKLIST

We have included this checklist to help answer some of the most frequently asked questions. In order to avoid possible delays in claims, please be sure to review and complete each step thoroughly. It is not necessary to return the checklist with your re-credentialing packet — this is for your reference.

☐ RE-CREDENTIALING APPLICATION

- ☐ Please note that you must submit a separate application for each state in Northeast Delta Dental's territory in which you practice. If you practice in multiple locations in one state, please submit one application with separate copies of page 2 for each location.
- ☐ Complete all fields entirely. If a particular field does not apply, please write N/A (Ex. Hospital Privileges, Specialty Residency).

☐ MALPRACTICE INSURANCE

- ☐ Proof of insurance must show your name and show that you are currently covered, as well as coverage amounts.

☐ SPECIALTY CERTIFICATE

- ☐ If you are a specialist, please provide a copy of your specialty certificate.

☐ MEDICARE ENROLLMENT

- ☐ If you are enrolled in Medicare, please provide proof of enrollment.

☐ MEDICARE PART D

If you have Opted In to Part D, please provide all of the following:

- ☐ Confirmation of Opting In to Part D
- ☐ Certificate of Completion - "Medicare Parts C and D General Compliance Training"
- ☐ Certificate of Completion - "Combating Medicare Parts C and D Fraud, Waste, and Abuse Training"

You may fax your completed re-credentialing paperwork to 603-223-1033.

Should you have any questions, please feel free to contact Provider Services at 1-800-537-1715, extension 1100, or by email at credentialing@nedelta.com.

Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
Phone – 603-223-1000
Fax – 603-223-1033
Email – credentialing@nedelta.com

Northeast Delta Dental Credentialing and Re-Credentialing Application

Instructions:

1. Each dentist participating with Northeast Delta Dental needs to complete this application in its entirety at least once every three (3) years.
2. Please note that you must submit a separate application for each state in Northeast Delta Dental's territory in which you practice. If you practice in multiple locations in one state, please submit one application with separate copies of page 2 for each location.
3. Please include current copies of the following documents with your application:
   - W-9 for each location in which you practice
   - Professional Liability Insurance Declaration Page showing policy limits, dentist's name, policy number, and effective date and expiration date
   - Completed and signed Participating Agreement for each practice location in which you participate (for credentialing only)

If you have any questions, please contact the Provider Services department at 1-800-537-1715, extension 1100.

General Information

First Name: _____ Middle Initial: _____ Last Name: _____

Title/Degree (e.g., DMD, DDS): _____

Gender: ◯ Male ◯ Female SSN#: _____ Date of Birth (mm/dd/yyyy): _____

Dental License State: _____ Dental License Number: _____

Dental License Expiration Date (mm/dd/yyyy): _____

Type 1 National Provider ID Number: _____

DEA or CDS Certification Eligible? ◯ Yes ◯ No

I currently practice as a:

◯ General Dentist
◯ Endodontist
◯ Oral Pathologist
◯ Oral Maxillofacial Radiologist
◯ Oral Surgeon
◯ Orthodontist
◯ Pediatric Dentist
◯ Periodontist
◯ Prosthodontist

If you are a specialist, are you Board Certified? ◯ Yes ◯ No
If you are a specialist, are you Board Eligible? ◯ Yes ◯ No

Practice Location(s)

Please complete for **each location** in which you practice. Make copies of this page as necessary.

Physical Address

Address 1: _____

Address 2: _____

City/Town: _____ State: _____ ZIP: _____

Tax ID Number: _____ Type 2 National Provider ID Number: _____

Mailing Address

Address 1: _____

Address 2: _____

City/Town: _____ State: _____ ZIP: _____

Phone Number (include area code): _____

Fax (include area code): _____

Email: _____

Website: _____

Please answer the following questions for each practice location:

1. What are the hours that this office is open?

   Monday: _____ to _____ NOTES: _____
   Tuesday: _____ to _____ NOTES: _____
   Wednesday: _____ to _____ NOTES: _____
   Thursday: _____ to _____ NOTES: _____
   Friday: _____ to _____ NOTES: _____
   Saturday: _____ to _____ NOTES: _____
   Sunday: _____ to _____ NOTES: _____

2. Are you accepting new patients at this office? ◯ Yes ◯ No

3. In addition to English, are any other languages spoken by you or your dental team (please list)?

   _____

4. Is this office handicapped accessible (complies with the American with Disabilities Act)? ◯ Yes ◯ No
   **Northeast Delta Dental recognizes that some established offices may be exempt from compliance with ADA requirements.*

5. Is this office convenient to public transportation? ◯ Yes ◯ No

6. Does your practice treat adults with disabilities at this office? ◯ Yes ◯ No

7. Does your practice treat children with disabilities at this office? ◯ Yes ◯ No

Education & Training

Dental School

Institution Name: _____

Mailing Address: _____

City/Town: _____ State: _____ ZIP: _____

Degree: _____

Years Attended: _____ Year Graduated: _____

Are you a foreign dental school graduate? ◯ Yes* ◯ No

**If yes, you must provide a copy of your certificate.*

General Dentistry Program / Residency / Internship

Institution Name: _____

Mailing Address: _____

City/Town: _____ State: _____ ZIP: _____

Dates Attended (mm/yyyy – mm/yyyy): _____ to _____

Type of Program: _____

Specialty Residency

Institution Name: _____

Mailing Address: _____

City/Town: _____ State: _____ ZIP: _____

Dates Attended (mm/yyyy – mm/yyyy): _____ to _____

Did you complete this program? ◯ Yes ◯ No

Specialty (please list) _____

Board Certified? ◯ Yes ◯ No

Type of Residency: _____

Other Post Graduate Education*

Institution Name: _____

Mailing Address: _____

City/Town: _____ State: _____ ZIP: _____

Dates Attended (mm/yyyy – mm/yyyy): _____ to _____

Did you complete this program? ◯ Yes ◯ No

**Please attach a copy of your post-graduate certificate/diploma*

Work History

Please list your professional work history for at least the past five (5) years, and provide an explanation for any gaps in work history greater than six (6) months. If you are a newly licensed practicing dentist, you may leave this section blank.

Position: _____

Employer Name: _____

Address: _____

City/Town: _____ State: _____ ZIP: _____

Phone Number (include area code): _____

Dates Worked (mm/yyyy – mm/yyyy): _____ to _____

Position: _____

Employer Name: _____

Address: _____

City/Town: _____ State: _____ ZIP: _____

Phone Number (include area code): _____

Dates Worked (mm/yyyy – mm/yyyy): _____ to _____

Hospital Privileges

Please list all hospitals where you currently have clinical privileges. Please indicate privilege status (Active/Admitting; Associate; Courtesy; Provisional; Other).

Hospital Name: _____

Address: _____

City/Town: _____ State: _____ ZIP: _____

Privilege Status: _____

Hospital Name: _____

Address: _____

City/Town: _____ State: _____ ZIP: _____

Privilege Status: _____

Have your hospital privileges ever been revoked or suspended or have you ever been refused membership on a hospital medical staff?

◯ Yes
This means you have had hospital privileges revoked or suspended, or you have been refused membership on a hospital medical staff.

◯ No
This means you have NEVER had hospital privileges revoked or suspended and you have NEVER been refused membership on a hospital medical staff.

If you answered "**Yes**", please explain. Use a separate page if necessary:

Insurance & Malpractice History

Please answer the following questions:

1. Do you carry malpractice insurance?

   ◯ Yes ◯ No

Current Insurance Carrier

Carrier Name: _____

Policy #: _____

Please inform Northeast Delta Dental of any change in your malpractice carrier or coverage amount.

2. Have you been involved in any malpractice lawsuits, claims, or settlements within the last five (5) years? This question is meant to capture settlements, judgments, payments (including payments paid following a demand letter but prior to a formal complaint), and pending claims (including demand letters).

   (Please note that Northeast Delta Dental will verify this response against the National Practitioner Data Bank and any available reports from the relevant Board(s) of Dental Examiners or Board of Dental Practice.)

   ◯ Yes

   This means you have a pending claim against you, whether in the form of a demand letter or formal lawsuit, or have entered into a settlement, judgment, or payment (including payments paid following a demand letter but prior to a formal complaint) to resolve a complaint within the last five (5) years.

   ◯ No

   This means you have NO pending claims whether in the form of a demand letter or formal lawsuit, and have NOT entered into a settlement, judgment, or payment (including payments made in response to a demand letter but prior to a formal complaint) to resolve a complaint within the last five (5) years.

If you answered "**Yes**", please explain. Use a separate page if necessary:

Health Status

Please answer the following questions:

1. Do you have any alcohol or substance dependency which may impair your ability to safely and competently practice dentistry or which may endanger your patients?

   ◯ Yes ◯ No

If you answered "**Yes**", please explain. Use a separate page if necessary:

2. Do you have any limitation which prevents you from performing any function of your position with or without accommodation?

   ◯ Yes ◯ No

If you answered "**Yes**", please explain. Use a separate page if necessary:

Professional Information

Please answer the following questions:

1. In the past five (5) years, have you been convicted of a felony that has not been annulled by a court?

   ◯ Yes
   This means that you have, within the last five (5) years, been convicted of a felony that has not been annulled by a court.

   ◯ No
   This means that you have NOT, within the last five (5) years, been convicted of a felony that has not been annulled by a court.

If you answered "**Yes**", please explain. Use a separate page if necessary:

2. Has your dental license been denied, revoked, suspended, or made subject to probation or any conditions, restrictions, or limitations in any state for any reason in the past five (5) years?

   ◯ Yes
   This means you have entered into or are currently subject to a consent decree or consent judgment with a Board of Dental Examiners/Practice or have been subject to any kind of discipline by a regulatory body within the past five (5) years.

   ◯ No
   This means you have NOT entered into and are NOT currently subject to a consent decree or consent judgment with a Board of Dental Examiners/Practice and have NOT been subject to any kind of discipline by a regulatory body within the past five (5) years.

If you answered "**Yes**", please explain. Use a separate page if necessary:

3. Have your privileges to practice (whether in an insurer network, in the military, or in any other setting) been suspended, lost, or limited in the past five (5) years due to disciplinary action?

   ◯ Yes
   This means that, within the past five (5) years, your network status, participation privileges, or other ability to practice has been restricted, limited, suspended, or terminated by any credentialing entity that is not a state Board of Dental Examiners/Practice. Only answer yes if this action was taken in response to quality of care concerns or non-administrative concerns. Do NOT answer yes if you let your participation status lapse or your privileges to practice were lost or limited for failure to timely submit forms or comply with administrative (and not clinical) policies.

   ◯ No
   This means that, within the past five (5) years, no entity has restricted, limited, suspended, or terminated network status, participation privileges, or other ability to practice for disciplinary reasons. You should answer No if you allowed your participation status to lapse.

If you answered "**Yes**", please explain. Use a separate page if necessary:

4. Have you been sanctioned, disciplined, reprimanded, suspended by, or expelled from participation in Medicare, Medicaid, SCHIP, or other federal or state health care programs or otherwise sanctioned by the Office of the Inspector General in the past five (5) years?

◯ Yes
This means that, within the past five (5) years, you have been sanctioned, disciplined, reprimanded, suspended by, or expelled from participation in Medicare, Medicaid, SCHIP, or other federal or state health care programs or otherwise sanctioned by the Office of the Inspector General.

◯ No
This means that, within the past five (5) years, you have NOT been sanctioned by, suspended by, or expelled from participation in Medicare, Medicaid, SCHIP, or other federal or state health care programs or otherwise sanctioned by the Office of the Inspector General.

If you answered "**Yes**", please explain. Use a separate page if necessary:

5a. Are you currently enrolled as a Medicare Provider? Note: This enrollment allows you to be paid for services you render for Medicare Part C (Medicare Advantage) plans that provide dental services and for your patients to receive benefits for Medicare Part D prescription drugs, lab orders, and referrals.
◯ Yes (If Yes, go to question 6) ◯ No

5b. Have you been certified as having completed the online Medicare Parts C and D Medicare Compliance Training ("Combating Medicare Parts C and D Fraud, Waste, and Abuse" and "Medicare Parts C and D General Compliance Training")? Note: This may, subject to your Medicare Part D status, allow you to receive payments for Medicare Part C dental services rendered by your office.
◯ Yes ◯ No (Yes or No, go to question 5c)

5c. Have you completed the necessary paperwork to opt-in to Medicare Part D? Note: Completing the paperwork to opt-in will allow your patients to receive benefits for prescriptions, lab orders, and referrals and, if you answered "Yes" to 5b, may also allow you to receive payments for Medicare Part C dental services rendered by your office.
◯ Yes (If Yes, go to question 6) ◯ No

5d. Have you completed the necessary paperwork to opt-out of Medicare? Note: Completing the paperwork to opt-out will allow your patients to receive benefits for prescriptions, lab orders, and referrals but will not allow you to receive payments for Medicare Part C dental services rendered by your office.
◯ Yes ◯ No

6. In the past five (5) years, have you met the infection control standards of the Centers for Disease Control and Prevention in all offices where you provide services?
◯ Yes ◯ No

Certification, Authorization, and Release

1. I hereby certify that all the information on this application is accurate and complete to the best of my knowledge and I agree to provide information as required to support this application. I understand that information which is found to be false or incomplete may result in denial or termination of my participation with Northeast Delta Dental.

2. I agree to notify Northeast Delta Dental of any changes to the information provided on this application including, but not limited to, changes in my malpractice coverage.

3. I understand that my application may require review of information from third parties, including, but not limited to the National Practitioner Data Bank, state licensing boards, specialty boards, Office of Inspector General (OIG), educational institutions, and malpractice carriers.

4. I authorize all applicable third parties, including the National Practitioner Data Bank, to release information directly to Northeast Delta Dental for the purpose of evaluating my application, credentials, and qualifications and for the purpose of updating any information requested in this application prior to my next re-credentialing.

Dentist Name (Please Print): _____

Dentist's Signature: _____

Date (mm/dd/yyyy): _____