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/Recredentialing Application

Instructions:

1. 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.
2. Please include current copies of the following documents with your application:
   - Professional Liability Insurance Declaration Page showing policy limits, dentist's name, policy number, and effective date and expiration date
   - Copy of DEA Certificate

Northeast Delta Dental participating providers are required to be re-credentialed at least once every three (3) years.
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, IPDH, Denturist): _____ SSN#: _____

Type 1 National Provider ID Number: _____

Gender: ☐ Male ☐ Female Personal Pronouns: _____ Date of Birth (mm/dd/yyyy): _____

Race/Ethnicity:

The following are based on the industry standard, FHIR. Select all that apply.

☐ American Indian or Alaska Native
☐ Asian (Asian Indian, Bangladeshi, Bhutanese…)
☐ Black or African American (Black, African American, African…)
☐ Hispanic or Latino (Spaniard, Mexican, Central American…)
☐ Native Hawaiian or Other Pacific Islander (Polynesian, Micronesian, Melanesian)
☐ White (European, Middle Eastern or North African, Arab)
☐ Prefer not to say
☐ I do not have the information to answer

Languages spoken or offered (including American Sign Language): _____

Interpretation/translation services offered: _____

Dental License State: _____ Dental License Number: _____

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

DEA or CDS Certification Eligible? ☐ Yes ☐ No

If you do not have a DEA Certificate, have alternate arrangements been made for your patients? ☐ Yes ☐ No

Do you offer Telehealth Services? ☐ Yes ☐ No

General Information Continued

I currently practice as a:

- ☐ General Dentist
- ☐ Endodontist
- ☐ Oral Pathologist
- ☐ Oral Maxillofacial Radiologist
- ☐ Oral Surgeon
- ☐ Orthodontist
- ☐ Pediatric Dentist
- ☐ Periodontist
- ☐ Prosthodontist
- ☐ IPDH
- ☐ Denturist

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

Do you treat disabled adults? ☐ Yes ☐ No
Do you treat disabled children? ☐ Yes ☐ No

Office Information-Please complete for <u>each location</u> (use additional page if 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: _____

Office hours that this practice is open:

Monday: _____ to _____ NOTES: _____

Tuesday: _____ to _____ NOTES: _____

Wednesday: _____ to _____ NOTES: _____

Thursday: _____ to _____ NOTES: _____

Friday: _____ to _____ NOTES: _____

Saturday: _____ to _____ NOTES: _____

Sunday: _____ to _____ NOTES: _____

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, precluded, 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, precluded, 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, precluded, 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 with the Centers for Medicare and Medicaid Services?

☐ Yes (If Yes, please go to question 5b) ☐ No (If No, please go to question 5d)

5b. Have you completed the Medicare Compliance and Fraud, Waste, and Abuse Compliance Training? Note: This is an annual requirement in order for you to receive payments for Medicare Part C dental services.

☐ Yes ☐ No

5c. Have you been precluded from participating in Medicare by the Centers for Medicare and Medicaid Services? Note: If you are a precluded provider, you understand you are no longer eligible for payment for services provided to Medicare beneficiaries and are prohibited from pursuing payment from the beneficiary. You are financially liable for those services if completed while precluded from Medicare.

☐ Yes ☐ No

5d. Have you completed the necessary paperwork to opt-out of Medicare? Note: If you are opted out, you may not receive payments for Medicare Part C dental services.

☐ 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.

5. I understand that Northeast Delta Dental shall maintain the confidentiality of credentialing and re-credentialing information and shall use such information for credentialing, re-credentialing, and network administration purposes or as otherwise permitted by participation agreements and the Northeast Delta Dentist Handbook.

Dentist Name (Please Print): _____

Dentist's Signature: _____

Date (mm/dd/yyyy): _____

Prior to returning completed application, please make sure to include a copy of the following:

- Copy of your current Professional Liability Insurance with the Declaration Page, listing the effective date and expiration date
- Copy of your current DEA Certificate
- New Provider or Provider adding a new location-Completed and signed Participating Agreement for each practice location in which you participate