PROVIDER APPLICATION CHECKLIST

HEALTHPLEX®
THE DENTAL BENEFIT EXPERTS℠

In order to expedite the credentialing process for your participation in a program administered by Healthplex, Inc., please use the checklist below to ensure that all essential documents are completed and returned to Healthplex, Inc.

Provider Credentialing Documents

Please complete, sign and return the following:

- ☐ Provider Personal Profile (*pages 1-4*)
  **Please complete one form for each individual dentist treating patients at a provider site.*
- ☐ Curriculum Vitae or summary of work history (*page 2*)
- ☐ Release and Authorization (*page 4*)
- ☐ Current Professional Liability Insurance Certificate of Coverage (*limits page with a valid expiration date*)*
- ☐ Current state license registration certificate*
- ☐ Current DEA (*Drug Enforcement Administration*) registration*
- ☐ Current CDS (*Controlled Dangerous Substances*) certificate* (NJ only)

**Note: Please photocopy and submit for each individual dentist.*

A postage paid envelope is included for your convenience, or you can submit all documents by fax or email. For questions regarding panel participation, please contact the Provider Relations Team at the contact information below:

Please mail, fax or email this completed form to:

Healthplex, Inc.
Attn: Provider Relations
333 Earle Ovington Boulevard, Suite 300
Uniondale, NY 11553-3608

F 516 228 9571
E providerrelations@healthplex.com

Please note that you have a right to: (1) review information in support of your application; (2) be informed of any information obtained during the credentialing proccess that varies substantially from the information provided by you; (3) correct erroneous information; and (4) upon your request, be informed of the status of your application.

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HEALTHPLEX DENTIST PERSONAL PROFILE

Please complete this form in ink.

Personal Data

Dentist's Name ☐ Owner ☐ Associate

Practice Name

Type of Practice ☐ General ☐ Endodontic ☐ Oral Surgery ☐ Orthodontic ☐ Pedodontic ☐ Periodontic

Languages Spoken by above Dr.

Office Address*

City | County | State | Zip

Office Tel. # | Fax # | Home Tel. #

Email Address | Gender: ☐ Male ☐ Female

Birthdate | SS#

**If more than one office, please list on seperate sheet.*

Licenses

Dental License # | State | Exp. Date

Are you licensed in any other states? ☐ Yes ☐ No | Other States | License #

DEA # | State | Exp. Date

CDS # | State | Exp. Date

Medicaid Provider ID # | National Provider ID #

Medicare Provider ID #

Education

Dental School | Year Graduated | Degree ☐ DDS ☐ DMD

Specialty | ☐ Board Certified ☐ Board Eligible ☐ Neither

Date of Certification | Certifying Board

Specialty Residency Facility | Date of Completion

Residency Location

CPR Certification ☐ Yes ☐ No | Expiration Date

Hospital Privileges

Do you <u>currently</u> have hospital admitting privileges? ☐ Yes ☐ No (If more than one hospital, indicate primary)

Hospital Name and Address: _____

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Insurance

Malpractice Carrier | Policy #

Amount of Coverage | Renewal Date

Office

Is the office wheelchair accessible? ☐ Yes ☐ No

Is the office equipped to treat wheelchair bound patients in their own wheelchair? ☐ Yes ☐ No

Is the office equipped with auxiliary aids and services (TTY/TDD, Braille/large print materials, etc.)? ☐ Yes ☐ No

Explain

Are you equipped to treat special populations (persons with disabilities)? ☐ Yes ☐ No

Explain

# of Operatories | Does office comply with OSHA guidelines? ☐ Yes ☐ No | Autoclave ☐ Yes ☐ No

Number of Employed Dentists (please identify below - a separate form must be completed for each)

Name | Specialty | Languages Spoken

Name | Specialty | Languages Spoken

Name | Specialty | Languages Spoken

Name | Specialty | Languages Spoken

# of Hygienists: | # of Clerical Assistants: | # of Dental Assistants:

Office Hours: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

Do you have 24 hour telephone coverage? ☐ Yes ☐ No

Please list covering providers that are participating with Healthplex:

1) Name

2) Name

Work History

(Please write a complete career history since dental school graduation below, including complete addresses)

Dates of Employment	Place of Employment
FROM: (MM/YY) TO: (MM/YY)	
FROM: (MM/YY) TO: (MM/YY)	
FROM: (MM/YY) TO: (MM/YY)	
FROM: (MM/YY) TO: (MM/YY)	

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Confidential Information

Please answer all questions and include ALL information regardless of time limitation.

1. Do you have any history of malpractice action (settlements, judgments, or otherwise)? ☐ Yes ☐ No
2. Do you have any malpractice cases pending? ☐ Yes ☐ No
3. Have you ever been convicted or named as a defendant in any criminal proceeding, or been convicted of any felony (e.g., fraud, narcotics)? ☐ Yes ☐ No
4. Has your license to practice dentistry ever been subjected to any revocation, suspension, probation, or other disciplinary action by any state licensing authority or dental society? ☐ Yes ☐ No
5. Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance programs (e.g., Medicaid or Medicare programs)? ☐ Yes ☐ No
6. Has your DEA certificate or state controlled substance license/certificate ever been denied, revoked or restricted in any way? ☐ Yes ☐ No
7. Have clinical privileges ever been denied, revoked, suspended or restricted in any way? ☐ Yes ☐ No
8. Do you have any physical or mental impairment that would cause you to be unable to perform the essential functions in your area of practice, without any threat to the health and safety of others? ☐ Yes ☐ No
9. Are you suffering from any communicable health condition that, considering the essential functions of your practice, could pose a health or safety risk to your patients? ☐ Yes ☐ No
10. Within the past three years have you had any substance abuse, or chemical dependency problems, which might affect your ability to practice dentistry in your area of expertise in any way? ☐ Yes ☐ No

For each question to which you answered YES, please attach an explanation, including without limitation:

1. The incident(s) upon which the action(s) were based, including pertinent dates.
2. How the matter was resolved, including any conditions and whether they have been met or are still pending.
3. List any payments and whether the payments were a result of settlement or judgment.
4. Describe in detail the specific clinical steps or process you instituted to prevent the recurrence of this situation.
5. List any continuing education courses you attended relating to this situation, including dates of attendance.

Signature _____ Date _____

Explanation _____

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Release and Authorization

I authorize Healthplex, Inc., its affiliates, subsidiaries, successors, employees, and agents to consult professional liability carriers, managed care organizations, State Boards of Dentistry and Education, and other persons or entities in order to obtain information concerning my qualifications, including without limitation my professional competence and conduct. I consent to release to Healthplex, Inc. any and all information that might be relevant to the evaluation of my qualifications, including all information that might otherwise be considered confidential or privileged. I authorize Healthplex, Inc. to release this information, as well as any quality assurance data relating to me, to any entity related to Healthplex, Inc. or its affiliates. I release Healthplex, Inc. and any and all persons or entities providing information about me to Healthplex, Inc. from any and all liability connected with or arising from the release of such information, provided that such party(ies) was acting in good faith and without malice. I further release Healthplex, Inc. from any and all liability for their acts performed in good faith and without malice in evaluating my application, and any decisions related to my application or credentialing status.

I understand that I have the burden of providing adequate information to Healthplex, Inc. to demonstrate my qualifications. I understand and agree that any misstatement or material omission in this application will constitute grounds for rejection of my application or summary dismissal as a participating provider in any and all entities managed by Healthplex, Inc. If any material change occurs in the information I have provided in this application, which in any way is relevant to my performing the essential functions of my practice, or affects my professional status in any way, I understand and agree that it is my obligation to notify Healthplex, Inc. within ten days of said occurrence. Failure to comply with this obligation may constitute grounds for my summary dismissal as a participating provider in any and all managed care networks maintained by Healthplex, Inc.

I understand that all statements on this application whether prepared by me or an employee are to be considered statements made by me.

I attest that the information contained in this application is correct and complete.

Full Name & Degree	Full Signature (in pen please)	Date

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