LIBERTY DENTAL PLAN
Making members shine, one smile at a time™

CREDENTIALING APPLICATION (Complete one application per provider)

PROVIDER GENERAL INFORMATION

*Fields marked by an asterisk are Required

*Last Name:	*First Name:	MI:	Suffix:	☐ Owner ☐ Associate	☐ DDS ☐ DMD	☐ Other (specify)	☐ Male ☐ Female
*Date of Birth:(MM/DD/YY) / /	*Social Security #: - -	*NPI Type 1: (Individual)		Alternate Languages Spoken:			
*Medicaid Provider? (If Yes, All NPI #'s must be registered with appropriate State Agency) ☐ YES ☐ NO	*Medicaid ID:	*Specialty:	CAQH ID:				

PRIMARY PRACTICE INFORMATION

☐ Check box if at multiple locations & roster attached.

*Practice Name (DBA):	*Practice Address:		
*City:	*State:	Zip Code:	County:
*Office Phone No.: ( ) -	*Office Fax No.: ( ) -	Office Email:	*TAX ID:
*Medicaid Office? (If Yes, All NPI #'s must be registered with appropriate State Agency) ☐ YES ☐ NO	*Medicaid ID:		*NPI TYPE 2: (Organization)
*Start Date: (MM/YYYY) /	Credentialing Contact:	Credentialing Phone No.: ( ) -	Credentialing Email:

WORK HISTORY

☐ Check box if graduated within the last 6 months.

*Please supply a 5-year work history including your current dental practice location. Any GAPS in employment of 6 months or longer, must be explained. Please attach additional pages if necessary.

☐ Check box if CV attached. If attaching a CV, ensure current location is listed and gaps are explained.

Practice Name:	Address, City, State, Zip	*From: (MM/YYYY)	*To: (MM/YYYY)
1.		/	Current
2.		/	/
3.		/	/
4.		/	/
5.		/	/
Gap Explanation:			

LICENSE AND REGISTRATION

☐ Check box if DEA Waiver attached.

Please enter all State Dental or Medical Licenses you currently hold. Please enter your DEA and or CDS Registration Number, if applicable. If you do not hold a DEA in the state for which you are applying, please submit a DEA Waiver. Attach clear legible copies of each state License and/or Registration.

*License #	*State:	*Expiration Date: (MM/DD/YY) / /	License #	State:	Expiration Date: (MM/DD/YY) / /
*DEA #:	*State:	*Expiration Date: (MM/DD/YY) / /	CDS #:	State:	Expiration Date: (MM/DD/YY) / /

SEDATION INFORMATION

Do you have current and valid state issued permits to administer Oral, Enteral, Parenteral, Intravenous, Inhalation, Conscious and/or Pediatric Conscious Sedation? If Yes, check all that apply. ☐ YES ☐ NO

Oral/Enteral	General	Parenteral	Intravenous	Inhalation	Conscious	Pediatric Conscious	Other:
☐	☐	☐	☐	☐	☐	☐	

SPECIALTIES AND BOARD CERTIFICATION

*Specialty Type (Check one) *Please submit copy of your Specialty Permit, if applicable in your state.

General Dentist	Endodontist	Pediatric Dentist	Periodontist	Oral Surgeon	Orthodontist	Prosthodontist	Other:
☐	☐	☐	☐	☐	☐	☐	

*Board Certified? ☐ YES ☐ NO (Please check "NO" if not applicable. Do not leave blank.)	Board Expiration Date: (MM/YY) /	Is this Specialty your Primary Specialty? ☐ YES ☐ NO

HOSPITAL PRIVILEGES

*Do you have Hospital Privileges? (Please check "No" if not applicable. Do not leave blank.) If "Yes" please list all hospitals where you currently have privileges. ☐ YES ☐ NO

*Hospital Name:	Address, City, State, Zip	*Phone No.
		( ) -
		( ) -
		( ) -

EDUCATION/TRAINING

Please enter all education and training completed. For schooling completed outside of U.S., please attach copy of School Certificate/Diploma.

*Education Type:	*City:	*State:	*Country:	*Date Graduated (**MM/YYYY**)	*Type (AEG, GPR, Internship, Residency, Fellowship, etc.)
*Dental School:				/	
Additional School:				/	
*Specialty School:				/	
Specialty School:				/	
Other Training:				/	

INSURANCE INFORMATION

Please attach a clear legible copy of your current Malpractice Insurance Certificate showing your **Full Name**, **Policy Number**, **Expiration Date** and **Amounts of Coverage**.

*Malpractice Insurance Carrier Name:	*Policy No. / FTCA Deeming Notice No.:	☐ Professional Liability Insurance ☐ Federal/State TORT
*Amounts of Coverage: Occurrence: $	*Aggregate: $	*Expiration Date: (MM/DD/YY) / /

*PROFESSIONAL QUESTIONS and ATTESTATIONS: (All questions must be answered)

YES	NO	#	Instructions: Check Yes or No. Do not leave any questions unanswered. For each "YES" response, please provide a detailed explanation on the Supplemental Form. You may also attach your written response or additional supporting documentation to the application.
☐	☐	1.	In the past five (5) years, have you had any gaps of six (6) months or greater, where you did not work as a practitioner in this current discipline? If "YES", please provide the reason(s) for any gap(s) on a separate page. Please mark "NO", if any gaps occur between education and employment.
☐	☐	2.	Has your license(s) to practice in any jurisdiction(s), whether completed or still pending, ever been denied, limited, suspended, revoked, not renewed, or have you ever been placed under probation, subject to disciplinary action or have you voluntarily relinquished any item in anticipation of any of these actions?
☐	☐	3.	Has your professional liability insurance ever been denied, suspended, canceled, or subjected to any disciplinary action?
☐	☐	4.	Have any of your DEA or State Drug Certificate registrations ever been denied, suspended, canceled, or subjected to any disciplinary action?
☐	☐	5.	Has your status as a provider or membership with any professional organization, ever been denied, suspended, canceled, sanctioned, or subjected to any disciplinary action? Are you currently under investigation by any municipal, state, federal or any other government agency, HMO, PPO or other prepaid health plan? (e.g. Medicare, Medicaid)
☐	☐	6.	Are your privileges or memberships at any hospital or institution (military service) currently under investigation or have they ever been denied, suspended, reduced, disciplined, or not renewed?
☐	☐	7.	Are you prevented from performing any procedures within the scope of privileges and duties as a healthcare provider?
☐	☐	8.	Do you currently, or did you in the last five years, engaged in the unlawful use of drugs, including the improper use of prescription drugs, to include any physical, mental or substance abuse problems that could, without reasonable accommodation, impede the your ability to provide care, according to accepted standards of professional performance; or pose a threat to the health or safety of patients?
☐	☐	9.	Do you have any felony or misdemeanor charges pending against you, other than a traffic violation, or have you ever been convicted or pleaded "nolo contendere" to a felony?
☐	☐	10.	Have you been involved, within the last ten years, or are you currently involved in ANY claims/lawsuits, settlements, or judgments (other than divorce or custody)? If YES, please provide detailed information on a separate sheet of paper including: docket # of the case, location of the court, the names of the party plaintiff(s) and defendant(s), description and date(s) of the incidents(s), your involvement, current disposition, and the amount of settlement.
☐	☐	11.	Are you currently practicing WITHOUT, or with and EXPIRED, Professional Liability/Malpractice Insurance?
☐	☐	12.	Have you ever been reported to the National Practitioner's Data Base?

I hereby make formal application for network participation with LIBERTY Dental Plan.

***DOCTOR'S SIGNATURE:** _____ ***DATE:** ____/____/____

(No Signature Stamps)

***PRINT NAME:** _____ ***LICENSE #:** _____ ***STATE:** _____

Information Release / Acknowledgments:

I authorize **VerifPoint/CreDENTIALs** or any **LIBERTY Dental Plan contracted ("CVO")**, 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 hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (under "Credentialing Information") by and between LIBERTY Dental Plan and other Healthcare Organizations (e.g. hospital medical staff, medical groups, independent practice associations (IPA's), health plans, health maintenance organizations (HMO's), preferred provider organizations (PPO's), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, businesses and individuals acting as their agents (collectively, "HealthCare Organizations), for the purpose of evaluating this application and re-credentialing application regarding my professional training, experience, character, conduct, judgment, ethics, records and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patients' records and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluation the qualifications of healthcare providers. I hereby release all persons and entities, including LIBERTY Dental Plan and its agent(s), engaged in quality assessment, peer review and credentialing on behalf of LIBERTY Dental Plan, from an liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation with LIBERTY Dental Plan, to the extent that those acts and/or communications are protected by state and federal law.

I, the undersigned, hereby certify that the information requested by the CVO is truthful, correct and complete in all respects and I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating provider with the affiliated organization contracted with the CVO. The undersigned hereby agrees to notify the CVO of any changes in the above information.

I understand that if LIBERTY Dental Plan denies my application or otherwise takes action that is adverse to my request for participation, LIBERTY Dental Plan and/or its Representatives may be obligated, under applicable law, to report such action to the National Practitioner Data Bank and/or other licensing or accreditation agencies.

***DOCTOR'S SIGNATURE:** _____ ***DATE:** ____/____/____

(No Signature Stamps)

***PRINT NAME:** _____

Supplemental Form

Please use this page to explain any 'Yes' answers checked on the Professional Questions and Attestations page.

Question Number	Summary

***DOCTOR'S SIGNATURE:** _____ ***DATE:** / /

(No Signature Stamps)

***PRINT NAME:** _____

ADDENDUM TO LIBERTY DENTAL PLAN PARTICIPATING PROVIDER APPLICATION

NOTICE OF PROVIDER CREDENTIALING RIGHTS

I. Right of Review

As an applicant for credentialing/re-credentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Dental Boards, and the National Practitioner Data Bank. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure.

You may request to review such information at any time by sending a written request via fax or letter to the Credentialing Department, P.O. Box 26110 Santa Ana, CA 92799-6110, fax number 800-268-0154. Following receipt of your request, you will be contacted by the Credentialing Department, within five (5) business days.

II. Notification of Discrepancy

You will be notified in writing, by fax or letter, when information obtained during primary source verification differs from information submitted on the application.

III. Correction of Erroneous Information

If you believe that erroneous information has been supplied to LIBERTY, you may correct such information by submitting written notification to the Credentialing Department at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to the address above within fifteen (15) business days.

Upon receipt of your notification, LIBERTY will re-verify the primary source information. If the primary source information has changed, an immediate correction will be made to your credentialing file. If the primary source information remains inconsistent you will be advised of through a letter, fax, or phone call. If proof of correction is required, then you must notify the credentialing department within ten (10) business days.