

Billing Tax ID Practice Name Practice Address Telephone Number

ASSOCIATE PROVIDER INFORMATION

Title D.D.S. D.M.D. Specialty: Endodontist Oral Surgeon Orthodontist Pedodontist Periodontist Prosthodontist

Last Name First Name Middle Initial Gender Male Female

Date of Birth Social Security # License # Rendering Provider NPI

Do you prescribe medications? NO YES Dental School Name Year Graduated

If yes, provide DEA # _____

SPECIALTY BOARD STATUS Are you Board Certified? NO YES If No, are you or have you been Board Eligible? NO YES

If Yes, Year of Board Certification _____ Expiration _____

PROFESSIONAL WORK HISTORY

Please list all present and previous dental work history within the past five (5) years. Please provide written explanation of any breaks in history greater than 6 months. Curriculum vitae accepted in lieu of completing the following table.

Hire Date (mm/yy)	Term Date (mm/yy)	Employer	Location Address	Reason for Leaving

PROFESSIONAL LIABILITY INSURANCE (Required coverage minimum: \$500,000 per incident, \$1,000,000 aggregate)

Carrier Limits Effective Date Term Date

HOSPITAL ADMITTING PRIVILEGES: Do you have hospital privileges? NO YES (please complete below)

Hospital Name Address Phone

CONFIDENTIAL INFORMATION

For any "Yes" response in this section, please provide a brief explanatory statement with your completed form.

1. Within the past five years up to and including the present, have you 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 provide a narrative and status for each case.	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you ever had any one 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: <ul style="list-style-type: none"> State license DEA, CDS, or other applicable narcotic registration Hospital or other health-care facility staff membership or privileges Medicaid or other government program participation HMO, PPO, or other managed care plan Employment as a health-care provider by a military service, hospital, HMO, or other health-care organization 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
3. Do you have any condition that, with or without accommodation, would make you unable to perform the essential functions within your area of practice or unable to perform such essential functions without health and safety of patients?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Within the past five years up to and including the present, have you used illegal drugs or have you had a chemical dependency or substance abuse problem?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime?	<input type="checkbox"/> YES <input type="checkbox"/> NO

REQUIRED SUBMISSIONS

Please attach legible COPIES of the following: State Dental License (wallet-size only) Specialty Board Certificate (if applicable)
 DEA Certificate (if applicable) General Anesthesia License (if applicable)

ATTESTATION

I, the undersigned, hereby certify that the information provided on this application 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 dentist with the dental plan. The undersigned hereby agrees to notify the dental plan of any changes in the above information.

Dentist's Signature (no signature stamps)

Date