

DENTAL CREDENTIALING FORM

Please print
Incomplete applications will not be processed

Provider Staff Office Checklist

The following documents are **REQUIRED** for credentialing and consideration for privileges to participate in Kentucky Medicaid.

- ___ 1. A **COMPLETED** Provider Application that is signed and dated
- ___ 2. A copy of **CURRENT** valid state license to practice dentistry
- ___ 3. A copy of **CURRENT** valid anesthesia license (if applicable)
- ___ 4. A copy of **CURRENT** valid DEA/CDS registration
- ___ 5. A copy of **CURRENT** professional liability insurance policy that indicates carrier name, policy number, expiration date, and policy limits
- ___ 6. A copy of professional liability claims history (if applicable)

Credentialing is the process of verifying credentials (i.e. training, licensing, hospital affiliations) of potential providers by primary sources. All providers are credentialed following the guidelines of the National Committee for Quality Assurance (NCQA) to ensure our members that they are receiving the best quality care possible. Using NCQA guidelines for credentialing will ensure an organization that the providers affiliated with their panel are the best in the dental field.

Initial Credentialing

Update/Change

Re-Credentialing

Name of Applicant

Last Name	First Name	Middle Name
Specialty		
Office Contact for Credentialing Information		

**Section I
Personal Information**

Name (Last, First, Middle) _____

Professional Degree (M.D., DDS, DMD): _____

Home Address: _____

City/State/Zip: _____

Home Phone: (____) _____ Years at this Address: _____

Previous Address if less than five (5) years at current address: _____

Other Names Used: _____

Date of Birth (MM/DD/YY): _____ UPIN# _____

Language Spoken: _____

U.S. Citizen? ____ Yes ____ No If no, status and Visa Number _____

Social Security # _____ Federal Employee ID# _____

Gender: Male Female CAQH # _____

Participating Health Plans

**Section II
Office Information**

Primary Office Address: _____

City/State/Zip: _____

Office Phones: (____) _____ (____) _____ Fax (____) _____

Office Email: _____ Office Manager: _____

Billing Address: _____

City/State/Zip: _____

Billing Office Contact Name and Title: _____

Type of Practice (L.L.C., Corp., etc): _____

Group/Corporate Name: _____

Medicare #: _____ Medicaid #: _____

Federal Tax ID: _____ NPI: _____ Taxonomy: _____

EPSDT Yes No If yes, EPSDT # _____

Please list other licensed/certified professional members of your practice:

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Please complete this page if you have additional offices:

Primary Office Address: _____

City/State/Zip: _____

Office Phones: (____) _____ (____) _____ Fax (____)

Office Email: _____ Office Manager: _____

Billing Address: _____

City/State/Zip: _____

Type of Practice (L.L.C., Corp., etc): _____

Group/Corporate Name: _____

Medicare #: _____ Medicaid #: _____

Federal Tax ID: _____ NPI: _____ Taxonomy:

EPSDT Yes No If yes, EPSDT # _____

If you practice at more than one location, do you require separate checks for each location? Yes No

Please list other licensed/certified professional members of your practice:

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

**Section III
Education**

List all, including undergraduate, beginning with the most recent.

School Name: _____

Degree Awarded: _____ Program Title: _____

Mailing Address: _____

Dates Attended (MM/YY) From: _____ To: _____ ADA approved? Yes No

School Name: _____

Degree Awarded: _____ Program Title: _____

Mailing Address: _____

Dates Attended (MM/YY) From: _____ To: _____ ADA approved? Yes No

School Name: _____

Degree Awarded: _____ Program Title: _____

Mailing Address: _____

Dates Attended (MM/YY) From: _____ To: _____ ADA approved? Yes No

School Name: _____

Degree Awarded: _____ Program Title: _____

Mailing Address: _____

Dates Attended (MM/YY) From: _____ To: _____ ADA approved? Yes No

School Name: _____

Degree Awarded: _____ Program Title: _____

Mailing Address: _____

Dates Attended (MM/YY) From: _____ To: _____ ADA approved? Yes No

**Section IV
Training**

Internships/Residencies/Fellowships/Preceptorships. List all, completed or not, beginning with the most recent.

Institution: _____

Mailing Address: _____

Dates Attended (MM/YY) From: _____ To: _____ Program Completed Yes No

Type of Training/Specialty: _____

Program Director: _____ ADA Approved? Yes No

Institution: _____

Mailing Address: _____

Dates Attended (MM/YY) From: _____ To: _____ Program Completed Yes No

Type of Training/Specialty: _____

Program Director: _____ ADA Approved? Yes No

Institution: _____

Mailing Address: _____

Dates Attended (MM/YY) From: _____ To: _____ Program Completed Yes No

Type of Training/Specialty: _____

Program Director: _____ ADA Approved? Yes No

Licensure Status(Please check all that apply)

General Dental License Limited Dental License Teacher's Dental License

Other _____

Are you recognized as a Specialist by the Dental Board? Yes No If yes, specify:

Do you hold a permit to administer general anesthesia? Yes No

Do you hold a permit to administer conscious sedation? Yes No

Do you utilize nitrous oxide in your practice? Yes No

**Section V
Professional Licensure**

List all current Professional Licenses. You must attach copies.

State:_____ Type:_____ Number:_____ Issue Date:_____ Expiration Date:_____

State:_____ Type:_____ Number:_____ Issue Date:_____ Expiration Date:_____

State:_____ Type:_____ Number:_____ Issue Date:_____ Expiration Date:_____

State:_____ Type:_____ Number:_____ Issue Date:_____ Expiration Date:_____

List all past Professional Licenses:

State:_____ Type:_____ Number:_____ Issue Date:_____ Expiration Date:_____

State:_____ Type:_____ Number:_____ Issue Date:_____ Expiration Date:_____

State:_____ Type:_____ Number:_____ Issue Date:_____ Expiration Date:_____

**Section VI
Certifications/Registration**

Please attach copies of any of the following certifications if held.

Federal DEA Registration Number: _____

Date Issued:_____ Expiration Date: _____

State CDS Number: _____ State: _____

Date Issued: _____ Expiration Date: _____

CPR Certified? Yes No Expiration Date: _____

If yes, List Classifications: _____

International Graduates: Are you ECFMG Certified? Yes No

USMLE/ECFMG Number: _____ Issue Date: _____

Hygienist Licensure: Please list the names of hygienist and licensure held

Name	License #	Expiration Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section VII
Specialty Information

Primary Specialty _____ Qualified Certified Not Applicable

Board Name: _____ Date of Initial Certification: _____

Does Board Certification Expire? Yes No If yes, Expiration Date: _____

Have you been recertified? Yes No N/A If yes, Recertification Date: _____

If Qualified, when does status expire? _____

If Qualified, date exam scheduled? _____

Board Certification results pending? Yes No

Sub-Specialty _____ Qualified Certified Not Applicable

Board Name: _____ Date of Initial Certification: _____

Does Board Certification Expire? Yes No If yes, Expiration Date: _____

Have you been recertified? Yes No N/A If yes, Recertification Date: _____

If Qualified, when does status expire? _____

If Qualified, date exam scheduled? _____

Board Certification results pending? Yes No

Section IX
Professional Liability Insurance Coverage

Please provide information on professional liability insurance for the past five (5) years.

Carrier Name: _____

Carrier Address: _____

Agent Name: _____ Policy Number: _____

Policyholder: _____

Amount of Coverage: _____
Coverage amount per occurrence Coverage amount per aggregate

Dates of Coverage: From _____ To _____

Carrier Name: _____

Carrier Address: _____

Agent Name: _____ Policy Number: _____

Policyholder: _____

Amount of Coverage: _____
Coverage amount per occurrence Coverage amount per aggregate

Dates of Coverage: From _____ To _____

Section X
Malpractice Claims History

Please provide information for all cases occurring in the past ten (10) years, beginning with the most recent.

None

Date of Occurrence: _____ Date Claim Filed: _____

Professional Liability Carrier involved _____

You were: Primary Defendant Co-Defendant

Describe Allegations against you: _____

Describe alleged injury to the patient: _____

Claimant/Plaintiff file suit in Court? Yes No If yes, date filed: _____

State Court Case Number: _____ State: _____ County: _____

Federal Court (U.S. District Court) Case Number: _____ District: _____

Pending Settled Arbitrated Awarded In Appeal Adjudicated

Withdrawn Other _____

Date of Occurrence: _____ Date Claim Filed: _____

Professional Liability Carrier involved _____

You were: Primary Defendant Co-Defendant

Describe Allegations against you: _____

Describe alleged injury to the patient: _____

Claimant/Plaintiff file suit in Court? Yes No If yes, date filed: _____

State Court Case Number: _____ State: _____ County: _____

Federal Court (U.S. District Court) Case Number: _____ District: _____

Pending Settled Arbitrated Awarded In Appeal Adjudicated

Withdrawn Other _____

Section XI
Additional Questions

1. Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered? Yes No
2. Have any of your professional licenses, in any state, ever been limited, sanctioned, voluntarily/involuntarily restricted, denied, revoked, suspended, surrendered, subjected to a consent order, placed on probation or cancelled? Yes No
3. Has your DEA license or state CDS certification ever been voluntarily or involuntarily suspended, restricted, revoked, surrendered, denied, or otherwise limited? Yes No
4. Has a dental license been denied you in any state? Yes No
5. Have you ever been placed on probation or asked to resign from an internship, residency, or other training program? Yes No
6. Have you ever been named a Defendant in any criminal case, other than misdemeanor traffic violations? Yes No
7. Has your malpractice insurance ever been cancelled, suspended, restricted, limited, special rated, or not renewed? Yes No
8. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified (terminated, suspended, restricted, revoked, limited or cancelled)? Yes No
9. Has information pertaining to you ever been reported to the National Practitioner Data Bank? Yes No
10. Have you ever been sanctioned or otherwise disciplined for a violation of ethical standards by a professional organization and/or a licensing board? Yes No
11. Are you engaged in the illegal use of drugs? Yes No
12. Within the last five (5) years, have you been sanctioned, reprimanded or otherwise disciplined in any manner by any state licensing authority or other professional board or peer committee for conduct related to the use of alcohol or the use of drugs? Yes No
13. Have you ever been the subject of a focused review by a peer review organization or similar agency including, but not limited to, Medicare, Medicaid, etc.? Yes No

ATTESTATION ADDENDUM

17. Do you have any mental or physical conditions impacting your ability to perform the essential functions of the position for which you are applying with or without accommodation? (ADA Act) **Y** **N**

I understand that I have the right to obtain the status and to review and correct erroneous information obtained by MCNA to evaluate my credentialing application at any time after submitting my application. This includes information obtained from primary source (e.g., malpractice insurance carriers, state licensing boards, NPDB, etc.) The review must take place within 6 months of the date on this application. Any corrections must be made in writing within 30 days of the review. This does not require MCNA to allow me to review references or recommendations or other information that is peer review protected. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of any professional competence, character, ethics and other qualifications and for resolving doubt about such qualifications.

I hereby affirm that the information submitted in this application and any addenda thereto is true to the best of my knowledge and belief and is furnished in good faith. I understand that willful falsification, significant omissions or willful misrepresentations may result in the rejection of my application by MCNA, termination of my current participation, employment, privileges and provider agreement with the MCNA Network. I understand that if my application is rejected for reasons relating to my professional conduct or competence, MCNA may report the rejection to the appropriate state licensing board and/ or NPDB as required.

Section XII
Authorization to Release Information

I authorize the Commonwealth of Kentucky and its affiliates, subsidiaries or related entities to consult with administrators, medical staff, malpractice carriers, educational institutions, government agencies, licensing boards, professional organizations, and other persons to obtain and verify information and I release the employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application;

I consent to the release to any person affiliated with the Commonwealth of Kentucky and its contractors or subcontractors all information that may be reasonably relevant to an evaluation of my professional competency, character, and moral and ethical, qualifications, including any information relating to any disciplinary action, suspension or limitation of privileges, and hereby release any such person providing such information from any and all liability for doing so.

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I further agree to notify the Commonwealth of any change to the information provided in this application within thirty (30) days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the Commonwealth.

WHOEVER KNOWINGLY OR WILLFULLY MAKES, OR CAUSES TO BE MADE, A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT SHALL BE SUBJECT TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAWS. (42USC 1320A-7B, CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS IS PRINTED ON PAGE 11) FAILURE TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED SHALL RESULT IN A DENIAL OF A REQUEST TO PARTICIAPTE IN OR TERMINATION OF THE CURRENT AGREEMENT WITH THE STATE AGENCY, AS REQUIRED BY 42 CFR 455.104 AND KRS CHAPTER 205 AS AMENDED.

Provider Authorized Signature: I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or for prosecution for Medicaid fraud. I certify that I have read and understand the "Medicaid Rules, Regulation, Policy and 42USC 1320a-7b" (pp. 9-11) to the best of my ability. I agree to abide by the Medicaid Program terms and conditions listed in this document, and I hold a license/certification to provide service corresponding to the information above and for which this agreement applies. I hereby authorize the Cabinet for Health and Family Services, the Kentucky Health Care Partnership to make all necessary verification concerning me and/or my medical practice/facility, and further authorize each educational institute, medical/license board or organization to provide all information that may be needed in connection with my application for participation in the Kentucky Medicaid Program. I also understand that the Dental Credentialing form or CAQH application is considered a continuation of my contract with the KY Department for Medicaid Services. I further certify that, if I keep medical records on an electronic database, those records are confidential and patient privacy is protected (KRS 205.510).

Applicant Signature

Date

Applicant's Printed Name

Phone Number

Mailing Address