Delta Dental of Illinois
Dentist Profile Initial Credentialing Application

DENTIST INFORMATION

Please type or print in black ink and complete the form in its entirety.

Last Name | First Name | MI

Individual NPI # (Type 1) | Date of Birth ____/___ /____ | Gender ☐ Male ☐ Female

DENTAL SCHOOL

Institution Name

City | State | Country | Phone #

Dates attended: From _____ /_____ (month/year) | To _____ /_____ (month/year)

Degree Received ☐ DMD ☐ DDS | Other

RESIDENCY/POST GRADUATE TRAINING

Institution Name

City | State | Country | Phone #

Dates attended: From _____ /_____ (month/year) To _____ /_____ (month/year)

Completed Training ☐ Yes ☐ No If no, expected completion date

If yes, degree received

BOARD CERTIFICATION

Are you Board Certified ? ☐ Yes ☐ No (if applicable, please attach certificate copy from **Specialty Board**)

Specialty/Subspecialty | Date of Certification

Expiration Date

LICENSURE

State	License Number	Date Issued ___/___/____	Expiration Date ___/___/____	License Status ☐ Active ☐ Inactive ☐ Pending
		___/___/____	___/___/____	☐ Active ☐ Inactive ☐ Pending
		___/___/____	___/___/____	☐ Active ☐ Inactive ☐ Pending

DRUG ENFORCEMENT ADMINISTRATION REGISTRATION (DEA) AND CONTROLLED SUBSTANCES CERTIFICATION(S)

DEA# | Expiration Date ___/___/_____ | ☐ Not Applicable to Practice

Controlled Substance Certificate: CS# | Expiration Date ___/___/____

☐ Not Applicable to Practice

EMPLOYMENT HISTORY (PRACTICE HISTORY)

Please list in chronological order beginning with most recent your employment/practice history for the past 10 years or from your post-graduate training if that is less than 10 years. List all experience including public health service, military service, and other business activities outside of dental practice. LEAVE NO GAPS IN CHRONOLOGY. If you did not practice due to a personal crisis, parenting, sabbaticals, etc. please note these in the employment history.

From ___/___/_____	Organization Name/Activity		
To ___/___/_____	Reason for Leaving		
City	State	Country	Phone Number

From ___/___/_____	Organization Name/Activity		
To ___/___/_____	Reason for Leaving		
City	State	Country	Phone Number

From ___/___/_____	Organization Name/Activity		
To ___/___/_____	Reason for Leaving		
City	State	Country	Phone Number

From ___/___/_____	Organization Name/Activity		
To ___/___/_____	Reason for Leaving		
City	State	Country	Phone Number

HOSPITAL AFFILIATION (IF APPLICABLE)

From ___/___/_____	Facility Name			
To ___/___/_____	City	State	Country	Phone Number

Admitting Privileges ☐ Yes ☐ No

From ___/___/_____	Facility Name			
To ___/___/_____	City	State	Country	Phone Number

Admitting Privileges ☐ Yes ☐ No

DISCLOSURE QUESTIONS

Is your office in compliance with the Occupational Safety and Health Administration (OSHA)?	☐ Yes ☐ No
Are you in compliance with the Center for Disease Control and Prevention (CDC) guidelines for infection control in dentistry?	☐ Yes ☐ No

DISCLOSURE QUESTIONS (CONT'D)

Please answer all questions below. For any questions answered "yes", please complete the Professional Liability Addendum.

Has your professional license ever been denied, terminated, relinquished, restricted, suspended or otherwise disciplined, including corrective action or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?	☐ Yes ☐ No
Has your Malpractice (Professional Liability) carrier ever refused or canceled your coverage or have you had any Malpractice (Professional Liability) claims or lawsuits brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? (This includes status of any pending claims previously reported.)	☐ Yes ☐ No
Has your participation, clinical privileges, employment or licensure ever been denied, terminated, relinquished, restricted, suspended or otherwise disciplined, including corrective action by licensing board, health related agency or organization, or is there a review pending?	☐ Yes ☐ No
Are there any charges pending or are you currently charged with or have you ever been indicted or found guilty of a felony, misdemeanor (other than a minor traffic violation), or other offense involving fraud, misrepresentation, dishonesty or deceit or been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment?	☐ Yes ☐ No
Are you currently using illegal drugs or do you have a condition in which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing a significant health or safety risk to your patients?	☐ Yes ☐ No
Has your DEA or Controlled Substance Certificate ever been denied, terminated, relinquished, restricted, suspended or otherwise disciplined, including corrective action or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?	☐ Yes ☐ No
Have you ever been sanctioned by any federal governmental agency (e.g. Medicare, Medicaid or the Office of Inspector General (OIG)?	☐ Yes ☐ No
Have you ever voluntarily relinquished your membership, participation, clinical privileges, employment, professional license, or registration (DEA or Controlled Substances), in lieu of disciplinary action or prior to or during an investigation into your professional conduct or competency?	☐ Yes ☐ No
Have you ever involuntarily relinquished your membership, participation, clinical privileges, employment, professional license or registration (DEA or Controlled Substances)?	☐ Yes ☐ No
Has your membership in any professional organization or your specialty board ever been voluntarily or involuntarily denied, terminated, limited, restricted, suspended or revoked?	☐ Yes ☐ No

Delta Dental of Illinois' process for Credentialing is not based on an applicant's race, ethnicity/nationality, gender, age, sexual orientation, or the types of patients or procedures in which the dentist specializes.

ATTESTATION AND CONSENT

I hereby certify the information provided herein is complete, true and correct. I agree to update this information as necessary so that it remains complete, true and correct by notifying Delta Dental of Illinois within 30 days of any changes to my license status, disclosure responses and liability coverage.

I understand that my application may require Delta Dental of Illinois to review information related to me on file with other entities, including but not limited to, state licensing boards, specialty boards, malpractice carriers, and the National Practitioner Data Bank Data Bank administered by the U.S. Government.

I authorize and release from liability all representatives of Delta Dental of Illinois, including any agent of Delta Dental of Illinois, my state licensing board, clinics, other institutions, professional societies, professional malpractice insurance carrier(s) and anystaff, for their acts performed in good faith and without malice in connection with the gathering and exchange of information as consented above or to release information as required by State or Federal laws, rules, or regulations.

Signature	Date

Printed Name

PROFESSIONAL LIABILITY ADDENDUM

Malpractice Claim (s)

Date of Occurrence	Settlement Amount	Current Status
Date Resolved	Name and Address of Insurance Carrier	

Details of Allegations

Date of Occurrence	Settlement Amount	Current Status
Date Resolved	Name and Address of Insurance Carrier	

Details of Allegations

Board Action (s)

Date of Occurrence	Date Resolved	Amount of Fine Paid

Details of Action (conditions, limitations, etc.); please attach copy of any action.

Date of Occurrence	Date Resolved	Amount of Fine Paid

Details of Action (conditions, limitations, etc.); please attach copy of any action.

CONFIDENTIALITY STATEMENT

Delta Dental of Illinois maintains all information gathered as part of the credentialing process in a confidential manner and will not communicate or reproduce any information obtained during the process unless otherwise required by law.

NOTICE OF APPLICANT'S RIGHTS

You may review or request the status of your application and information at any time during the verification process. This does not include documents protected by applicable state or federal laws. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to correct erroneous information submitted by another party. This includes information submitted by an outside source such as state license boards, malpractice insurance carriers, hospitals, and the National Practitioner Data Bank.

DELTA DENTAL®

Delta Dental of Illinois
Initial Credentialing Dental Office Profile

PRACTICE INFORMATION

Please type or print in black ink and complete the form in its entirety.

Office Name (Doing Business Name As (DBA) to be listed in the directory)	Corporate NPI (Type 2)

Office Address	City/State/Zip

Payment Address (if different from office address)

Telephone #	Fax #	Office Manager

Dr. ☐ Owner ☐ Associate

Business TIN	Business Name (Must Match the IRS Issued Tax Return or Coupon Payment Book)

Email Address	Publish in Directory ☐ Yes ☐ No

Website Address	Publish in Directory ☐ Yes ☐ No

Extended Office Hours (check all that apply) ☐ Before 8:00 a.m. ☐ After 7:00 p.m. ☐ Weekends

Are you accepting new patients?	☐ Yes ☐ No
Is your office handicap accessible?	☐ Yes ☐ No
Does your office provide free parking?	☐ Yes ☐ No
Is the office near public transportation?	☐ Yes ☐ No
Does the office submit claims electronically?	☐ Yes ☐ No
Does the office have internet access?	☐ Yes ☐ No
Does your office provide treatment for children with disabilities?	☐ Yes ☐ No
Does your office provide treatment for adults with disabilities?	☐ Yes ☐ No

List any languages spoken in your office other than English

ADDITIONAL PRACTICE LOCATION(S)

Please type or print in black ink.

Office Name (Doing Business Name As (DBA) to be listed in the directory)	Corporate NPI (Type 2)
Office Address	City/State/Zip
Payment Address (if different from office address)	
Telephone # / Fax #	Office Manager

Office Name (Doing Business Name As (DBA) to be listed in the directory)	Corporate NPI (Type 2)
Office Address	City/State/Zip
Payment Address (if different from office address)	
Telephone # / Fax #	Office Manager

Office Name (Doing Business Name As (DBA) to be listed in the directory)	Corporate NPI (Type 2)
Office Address	City/State/Zip
Payment Address (if different from office address)	
Telephone # / Fax #	Office Manager

For Administrative Use Only: License(s) ☐ - NPI(s) ☐ - DEA ☐ or Explanation ☐ - OIG ☐ - Liability Insurance ☐ Completed Attestation ☐ - Attachments ________ Dentists Signature ☐ Date ☐ - Verified by & Date: ______________________ Entered by & Date: ____________________________

DELTA DENTAL®

Delta Dental of Illinois
Initial Credentialing Checklist 2018

THE INITIAL CREDENTIALING APPLICATION DOCUMENTS SHOULD BE TYPED, LEGIBLY PRINTED IN BLACK INK OR ELECTRONICALLY GENERATED. PLEASE SUBMIT THE FOLLOWING DOCUMENTS WITH YOUR COMPLETED APPLICATION.

Please check boxes below to indicate documents are enclosed.

- ☐ Completed Dental Office Profile
- ☐ Completed Dentist Profile
- ☐ Copy of the Declaration Page (Face Sheet) of your Malpractice Insurance Policy*
- ☐ Copy of current dental license
- ☐ Copy of current DEA registration, if applicable
- ☐ Copy of Controlled Substance Certificate, if applicable
- ☐ Copy of an IRS/Department of Treasury issued document e.g. 147c or SS4 form, which verifies your Business TIN and Name as registered with the IRS. If you do not have an acceptable IRS document, please have the Owner Dentist call IRS Customer Service (800-829-0115) and request a faxed copy of the form.

*Note: Delta Dental of Illinois requires coverage to be at a minimum of $1,000,000 per occurrence and $3,000,000 in aggregate

ENROLL IN DIRECT DEPOSIT FOR DELTA DENTAL OF ILLINOIS AND ENJOY THESE BENEFITS

- Quicker Payments
- Safe & Secure Delivery of Payment
- Explanations of Payments by Fax or Email
- No Cost to your Office
- Electronic Posting of Payments (for compatible practice management programs)

Visit deltadentalil.com/dentist, login to the Dentist Connection and select Direct Deposit to access the Direct Deposit enrollment form and additional information. Completed forms must be signed and dated with a voided check or deposit slip and sent to Delta Dental of Illinois Professional Relations Department by:

Fax: 630-983-4034
E-Mail: psmailbox@deltadentalil.com
Mail: Delta Dental of Illinois, Attn: Professional Relations Department, 111 Shuman Blvd., Naperville, IL 60563

Please contact Delta Dental of Illinois' Provider Relations Department at 630-718-4990 or pr@deltadentalil.com with questions.