

Thank you for your interest in participating in the Deseret Healthcare dental panel.

Following is a confidential *Dental Provider Application Form*. This form should be filled out and returned to Deseret Healthcare. All applicable sections must be completed. **A Curriculum Vitae and copies of the following must be included (if applicable) with the application:**

- Copy of Board certification/eligibility for any specialty training you may have
- Current State License and Business License
- DEA Controlled substance registration certificate
- Certificate of Professional Liability Insurance (showing coverage amounts)
- Verification of hospital privileges
- Current W-9 filing

Please note an incomplete application will delay the process. Once the completed application and associated documents are received, the Provider Quality and Credentialing Committee will review the application and verify the information provided. The committee will review the need of DMBA participants in your area to ascertain the necessity of you being added to the panel. **Please understand that this application in no way guarantees addition to our panel.** The application process can take between 60 and 90 days.

Deseret Healthcare
Healthcare Systems



60 East South Temple • P.O. Box 45530
Salt Lake City, Utah 84145
Telephone 1-801-578-5600 • Toll Free 1-800-777-3622
Fax Number 1-801-578-5933 • Web site: www.dmba.com

Check One:

<input type="checkbox"/> General Practice	<input type="checkbox"/> Prosthodontics
<input type="checkbox"/> Endodontics	<input type="checkbox"/> Pediatric Dentistry
<input type="checkbox"/> Oral / Maxillofacial Surgery	<input type="checkbox"/> Periodontics
<input type="checkbox"/> Other _____	

DESERET MUTUAL DENTAL PROVIDER APPLICATION

PROVIDER INFORMATION

NAME (LAST, FIRST, MIDDLE) _____ DEGREE(S) _____

SOCIAL SECURITY NUMBER _____ BIRTH DATE _____ Male Female

DENTAL LICENSE NUMBER AND STATE _____ EXPIRATION DATE _____ DRUG ENFORCEMENT ADMINISTRATION NUMBER _____ EXPIRATION DATE _____

LANGUAGES SPOKEN _____

EDUCATION AND TRAINING

Institution	City and State or Country, if outside U.S.	Start Date (Month/Year)	Completion Date (Month/Year)
DENTAL SCHOOL	_____	_____	_____
SPECIALTY TRAINING	_____	_____	_____
OTHER EDUCATION / TRAINING	_____	_____	_____

LICENSURE

Indicate your current state license: _____ Year obtained: _____

Please list any other states or countries where you have held a dentistry license:

State / Country	License Number	Year Obtained	Year Relinquished	Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please attach a copy of board certification for any specialty training you may have.

SPECIALTY _____ General Anesthesia Conscious Sedation

PRACTICE LIMITED TO _____ OTHER CERTIFICATION / PERMITS _____

PROFESSIONAL LIABILITY INSURANCE

Please list the malpractice insurance carrier that provides your professional liability coverage.

CARRIER NAME	POLICY NUMBER	YEAR COVERAGE BEGAN	AMOUNT PER OCCURRENCE/AGGREGATE
_____	_____	_____	_____

PROFESSIONAL AFFILIATIONS

Local Society State Association American Dental Association

Specialty _____

Other _____

PRACTICE LOCATIONS

Do you practice at more than one location? Yes No

If yes, please fill in the information below pertinent to your **primary** practice. For other practices, fill in the information on the last page of this application.

PRIMARY PRACTICE TAX IDENTIFICATIONS

Claims submitted for this location will have the following provider identification:

Federal tax Identification number _____

This identification number is registered with the IRS under the following name _____

PRIMARY PRACTICE OFFICE ADDRESS

OFFICE NAME _____

STREET ADDRESS _____ SUITE NUMBER _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____ FAX NUMBER _____ OFFICE MANAGER NAME _____

EMAIL ADDRESS _____ WEB SITE _____

BILLING OFFICE ADDRESS (If different from above.)

BILLING CONTACT NAME (IF DIFFERENT FROM OFFICE MANAGER) _____ BILLING ENTITY NAME (IF APPLICABLE) _____

STREET ADDRESS _____ SUITE NUMBER _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____ FAX NUMBER _____

OTHER OFFICE INFORMATION

Does your office submit claims electronically? Yes No

What is the name of your practice management computer software vendor? _____

Are you accepting new patients? Yes No

Regular Office Hours:

Sunday _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____

DOCUMENT CHECKLIST

You must include legible copies of the following documents with your application:

- Current state license
- Current business license
- Current W-9 filing(s)
- If you completed training or residency in oral/maxillofacial surgery, verify in writing or include a copy of your board certification/eligibility

ADDITIONAL PROVIDER INFORMATION

1. Yes No In any jurisdiction, has your license to practice medicine or other professional registration/license ever been terminated, suspended, limited, restricted, subject to probationary conditions, or subject to a consent agreement or stipulation? Are any such actions pending?
2. Yes No Regarding your license to practice medicine or other professional registration/license in any jurisdiction, to your knowledge have you ever been the subject of a professional or state licensing board investigation or action, or have you had action taken against you by a governmental agency or law enforcement body for your alleged failure to comply with laws, statutes, regulations, or other legal requirements applicable to practicing your profession or rendering service to patients? Are any such actions pending?
3. Yes No Has your Drug Enforcement Administration (DEA) registration ever been terminated, suspended, limited, restricted, subject to probationary conditions, or subject to a consent agreement or stipulation? Are any such actions pending?
4. Yes No Has your license to prescribe or administer state-controlled substances ever been terminated, suspended, limited, restricted, subject to probationary conditions, or subject to a consent agreement or stipulation? Are any such actions pending?
5. Yes No Regarding your license to prescribe or administer state-controlled substances, to your knowledge have you ever been the subject of a professional or state licensing board investigation or action, or have you had action taken against you by a governmental agency or law enforcement body for your alleged failure to comply with laws, statutes, regulations, or other legal requirements applicable to practicing your profession or rendering service to patients? Are any such actions pending?
6. Yes No Has your participation in any provider or private/commercial health insurance program ever been relinquished, terminated for cause, suspended, restricted, or sanctioned? Are any such actions pending?
7. Yes No Have you ever practiced medicine without malpractice insurance, been denied professional liability insurance, had your coverage involuntarily cancelled, or received written notice of intent to deny coverage?
8. Yes No In the past five years, has your professional liability insurer or malpractice insurance carrier placed an individualized limitation, reduction, or restriction on the scope of your insurance coverage, or otherwise cancelled or refused to renew your coverage on an individual basis?
9. Yes No Have you ever had malpractice suit(s), professional liability claim(s), written notification(s) alleging malpractice and specifying one or more breaches in the standard of care on your part, or claim(s) subject to a pre-litigation panel hearing? Are any such actions pending?
10. Yes No Has money ever been paid on your behalf in an out-of-court settlement or judgment on a professional liability claim or complaint, regardless of whether or not it was reported to your insurance carrier or a malpractice suit was filed?
11. Yes No Has a final judgment, settlement, arbitration, mediation, or court action ever been entered against you or agreed to by you in a malpractice or professional liability case, regardless of whether or not it was reported to your insurance carrier or a malpractice suit was filed?
12. Yes No Has your staff membership, employment, or contractual participation at a hospital or other licensed health care facility ever been terminated, suspended, limited, restricted, subject to probationary conditions, or subject to a consent agreement or stipulation, either voluntarily or involuntarily? Are any such actions pending? (Answer if applicable.)
13. Yes No Have any of your clinical privileges ever been terminated, suspended, limited, restricted, subject to probationary conditions, or subject to a consent agreement or stipulation, either voluntarily or involuntarily? Are any such actions pending? (Answer if applicable.)
14. Yes No Has your affiliation or status at any other institution ever been terminated, suspended, limited, restricted, subject to probationary conditions, or subject to a consent agreement or stipulation, either voluntarily or involuntarily? Are any such actions pending? (Answer if applicable.)
15. Yes No Have you ever withdrawn your application for medical staff membership or employment at a facility to avoid an adverse outcome? (Answer if applicable.)

16. Yes No Has your academic appointment ever been terminated, suspended, limited, restricted, subject to probationary conditions, or subject to a consent agreement or stipulation, either voluntarily or involuntarily? Are any such actions pending? (Answer if applicable.)
17. Yes No Have you ever been a defendant in a criminal proceeding related to the practice of medicine?
18. Yes No Have you ever been convicted of, plead guilty to, or plead no contest to a felony?
19. Yes No Have you ever been a defendant in a criminal proceeding related to crimes against children?
20. Yes No Have you ever been convicted of any crime (other than a minor traffic violation)?
21. Yes No Have you ever been convicted of violating a state or federally-controlled substance, drug, or narcotic law?
22. Yes No Have you ever been convicted of fraud?
23. Yes No Have you ever been convicted of, plead guilty to, or plead no contest to a misdemeanor (other than a minor traffic violation)?
24. Yes No Have you ever had membership in a medical organization refused, relinquished, revoked, suspended, limited, or not renewed other than at your own request?
25. Yes No Do you have or have you been diagnosed with a physical or mental health problem or chronic illness that can't be reasonably accommodated and that might substantially interfere with your ability to practice?
26. Yes No Do you require accommodation to fulfill your functions and obligations in your practice?
27. Yes No Within the past 10 years, have you been treated, are you presently being treated, or have you been advised to seek treatment for narcotic, sedative, alcohol, or other drug abuse or addictions?
28. Yes No Within the past 10 years, have you used or are you currently using illegal drugs?
29. Yes No Has your board certification ever been denied, not renewed, or relinquished for disciplinary reasons, either voluntarily or involuntarily? Are any such actions pending? (Answer if applicable.)
30. Yes No Has your board eligibility, certification, or recertification status changed (other than changing from eligible to certified)? (Answer if applicable.)

If you answered "yes" to any of these questions, please include information about your situation with this application.

ATTESTATION

I agree all statements, answers, and information provided with this application are true and accurate. I understand any misstatements or omissions may result in Deseret Mutual not accepting my application or terminating my provider agreement.

If changes occur that materially affect the information in the application, I agree to notify Deseret Mutual in writing within 30 days of the changes, whether they occur before or after I enter into a provider agreement with Deseret Mutual.

I understand I am not accepted as a participating provider until I receive written notice of approval from Deseret Mutual.

I understand this information will be kept confidential, respecting my right to privacy, and will be examined only by qualified Deseret Mutual personnel.

NAME (PLEASE PRINT)

SIGNATURE

DATE

ADDITIONAL PRACTICE LOCATION(S) (If more than one additional location, photocopy this page as needed.)

NAME _____ DATE _____

Claims submitted for this location will have the following provider identification:

Federal Tax Identification Number _____

This identification number is register with the IRS under the following name _____

My Social Security Number _____

OFFICE ADDRESS

OFFICE NAME _____

STREET ADDRESS _____ SUITE NUMBER _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____ FAX NUMBER _____ OFFICE MANAGER NAME _____

EMAIL ADDRESS _____

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