

Connection DENTAL Provider Application



Reserved for office use only

General Information PLEASE PRINT IN BLACK INK OR TYPE YOUR ANSWERS. THANK YOU.

Last Name _____ First Name _____ MI _____ Suffix _____

Degree DDS DMD
 Social Security Number _____ Gender M F Date of Birth ____/____/____

License and Identification Numbers

Dental License Number _____ State _____ Expiry Date ____/____/____ Federal DEA Number _____ Expiry Date ____/____/____
 Dental License Number _____ State _____ Expiry Date ____/____/____ State DEA Number _____ State _____ Expiry Date ____/____/____
 NPI # Individual _____ Group _____

Have you previously been licensed in any other state? Yes No If yes, when and what state _____

Practice and Office Information

PLEASE LIST ALL OFFICE LOCATIONS WHERE YOUR PATIENTS ARE TREATED. IF YOU HAVE MORE THAN TWO LOCATIONS, PLEASE ATTACH A SHEET LISTING THE OTHER LOCATIONS.

<p>Primary Location (Defined as the location where you practice the majority of your time.)</p> <p>Provider start date at this location ____ / ____ / ____ <small>Month Day Year</small></p> <p>If we have questions about your application, give us a contact name _____</p> <p>Name of Practice _____</p> <p>Office Manager/Contact Name _____</p> <p>Street Address _____</p> <p>City _____ State _____</p> <p>County _____ Zip Code _____</p> <p>Office Phone Number (____) _____-_____ Office Fax Number (____) _____-_____ Tax ID Number (TIN) _____</p>	<p>Additional Location</p> <p>Provider start date at this location ____ / ____ / ____ <small>Month Day Year</small></p> <p>Name of Practice _____</p> <p>Office Manager/Contact Name _____</p> <p>Street Address _____</p> <p>City _____ State _____</p> <p>County _____ Zip Code _____</p> <p>Office Phone Number (____) _____-_____ Office Fax Number (____) _____-_____ Tax ID Number (TIN) _____</p> <p>Email Address _____</p>
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Mailing Address

Name _____

City _____ State _____

Phone Number _____ Fax Number _____
 (____) _____ - _____ (____) _____ - _____

Street Address _____

County _____ Zip Code _____

Contact Name _____

If you have a separate billing office, please complete.

Name of Billing Office _____

City _____ State _____

Billing Office Phone Number _____ Fax Number _____
 (____) _____ - _____ (____) _____ - _____

Street Address _____

County _____ Zip Code _____

Office Manager/Contact Name _____

Patients' Bill of Rights

Please indicate which services you provide.

Workers' Compensation Yes No

New Patients Yes No

Handicap Access Yes No

Difficult to Schedule New Patient Appts Yes No

Accepts Medicare/Medicaid Yes No

Weekend Hours Yes No

Evening Hours Yes No

24/7 Coverage Yes No

Same Day Appointments Yes No

Office Hours
 M _____ T _____ W _____ TH _____ F _____ S _____ SU _____

Patient Age Limits _____ Minimum Age _____ Maximum Age _____ Language(s) spoken in office other than English _____

Practice or Employment History

Please provide history of the LAST FIVE YEARS. Please attach a separate sheet if necessary. If lapse of employment is greater than six months, attach a written explanation.

Name of Employer _____

Street Address _____

City _____ State _____

Zip Code _____ Phone Number _____
 _____ - _____ (____) _____ - _____

Employed Begin Date ____/____/____ End Date ____/____/____
 Mo. Yr. Mo. Yr.

Job Title _____

Reason for Leaving _____

Name of Employer _____

Street Address _____

City _____ State _____

Zip Code _____ Phone Number _____
 _____ - _____ (____) _____ - _____

Employed Begin Date ____/____/____ End Date ____/____/____
 Mo. Yr. Mo. Yr.

Job Title _____

Reason for Leaving _____

Specialty(ies) Information

General Dentistry? Yes No

Do you administer general anesthesia or conscious sedation? Yes No

If you do, certification date _____

Name of Certifying Entity _____

Street Address _____

City _____ State _____

Zip Code _____ Phone Number (____) _____

If your practice is other than general dentistry, please complete information below for your ADA Board Specialty.

Name of ADA Specialty _____

Name of Certifying Board _____

Board Certified Board Eligible

Date Certified ____/____/____ Valid Until ____/____/____

Name of Additional ADA Specialty _____

Name of Additional Certifying Board _____

Board Certified Board Eligible

Date Certified ____/____/____ Valid Until ____/____/____

Additional Specialties _____

Educational Background

Dental School Name _____

Street Address _____

City _____ State _____

Zip Code _____ Graduation Date ____/____/____

If applicable, Foreign Graduate Number _____

Hospital Affiliations (IF APPLICABLE)

Hospital Name _____

Street Address _____

City _____ State _____

Zip Code _____

Professional Liability Insurance Information

Name of Insurance Carrier and Phone Number _____

Street Address _____

City _____ State _____

Zip Code _____

Policy Number _____

Date Insured ____/____/____ Expiry Date ____/____/____

Per Occurrence \$ _____ Aggregate \$ _____

Malpractice Litigation Information PLEASE ATTACH AN EXPLANATION OF EACH MALPRACTICE ACTION WITH THE DATE OF OCCURRENCE.

Number of cases currently open _____ Number of cases closed with payment _____

Number of cases closed without payment _____

Professional Health Status PLEASE ATTACH A BRIEF EXPLANATION FOR ANY YES ANSWERS.

Are you or have you been subject to:

- | | | | |
|--|--|--|--|
| Suspension as a Medicare or Medicaid provider? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suspension or limitation of hospital privileges? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Professional liability insurance denied, cancelled or not renewed? | <input type="checkbox"/> Yes <input type="checkbox"/> No | DEA licensing investigation or action? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| State licensing investigation or action? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Guilty plea or conviction of a felony or misdemeanor? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Revoked or suspended license? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic illness, physical defects or substance abuse that would impair your ability to practice? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Do you currently use illegal drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Authorization

Participating Provider hereby certifies that the information provided on the Credentialing Application is true and complete and correct to the best of his or her knowledge. Participating Provider hereby authorizes GEHA to contact individuals and organizations to obtain information pertaining to his or her qualifications for the credentialing and any subsequent recredentialing processes. Participating Provider agrees that GEHA, its subsidiaries, employees or representatives, and individuals or organizations providing information to GEHA shall not be liable for any act or omission related to the verification of the information provided in the Credentialing Application or recredentialing process. GEHA will treat information in the Credentialing Application that is not publicly available as confidential, unless disclosure is required by law. Participating Provider agrees to advise GEHA of any changes in the information provided on the Credentialing Application. Participating Provider understands that submission of the Credentialing Application does not guarantee participation in the Connection Dental Network. A photocopy of this page shall be considered a valid authorization.

Dentist Printed Name _____

Dentist Signature _____ Date _____
(Original Signature Required)

Indicate Sole Proprietor Partnership
 Professional Corporation Other, please explain _____

Credentialing Information (If different than practice location, please list)

_____	Office Phone Number (_____) _____ - _____
Address _____	Office Fax Number (_____) _____ - _____
City _____ State _____ Zip Code _____	Contact _____

IMPORTANT REQUIRED INFORMATION

We must have the following information in order for us to process your Application.

- | | |
|--|---|
| <input type="checkbox"/> Copy of Your DEA Certificate | <input type="checkbox"/> Proof of Malpractice Coverage |
| <input type="checkbox"/> Completed Application
(Please include all separate sheets and any requested written explanations.) | (Include copy of the Certificate of Insurance or policy face sheet which reflects expiry date and malpractice limits) |
| <input type="checkbox"/> Original Signed Participating Provider Agreement | <input type="checkbox"/> Signed W-9 |
| <input type="checkbox"/> Copy of Your Current State License | <input type="checkbox"/> Copy of Board/Specialty Certified (if applicable) |
| <input type="checkbox"/> Letters of reference or recommendation or oversight from supervisors (North Carolina Providers only) | |

If you have any questions about this Application, call toll free (800) 505-8880.



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