G.E.H.A | Connection Dental Network

Connection Dental Network – Provider Application

Please fill out as shown on provider license.

urac ACCREDITED Dental Network Expires 08/01/2025

connectiondental.com

Your application cannot be processed without the following:

Completed, signed, and dated application, including:

- ☐ Last five years of dental work history, with explanations of any gaps of 180 days or more
- ☐ New graduates with less than five years' work history must account for gaps of 180 days or greater between licenser date and work history start date
- ☐ Completion dates for all dental training and education

Completed, signed and dated professional questions and attestation within 120 days prior to submission

- ☐ Include any required written explanations, if applicable

Completed, signed, and dated Participating Provider Agreement

- ☐ 1st page of fee schedule that applicant received from GEHA Connection Dental Network – if not submitted fee schedule will be assigned by GEHA Connection Dental Network

Copy of current, professional malpractice insurance declaration page

Additional items that may be requested:

- ☐ Copy of DEA, sedation and anesthesia licenses and/or a wavier for all states in which you practice. Please include a copy of all active dental licenses.
- ☐ Copy of diploma if foreign educated or trained

Additional location forms can be found at connectiondental.com

General information PLEASE COMPLETE EACH SECTION IN BLACK INK. IF A QUESTION IS NOT APPLICABLE, WRITE "N/A." ALL SECTIONS MUST BE COMPLETED

Last name:	First name:	MI:	Suffix:
Other names are known by:		Degrees: DDS ☐ DMD ☐ BDS ☐ MD ☐ Other ☐	
Social Security Number:	Male ☐ Female ☐	Date of birth:	
NPI 1 (Individual):	Race:	Ethnicity:	
Languages other than English spoken by dentist:			

G.E.H.A / Connection Dental Network follows the NCQA guidelines and as such organizations must comply with all applicable federal and state civil rights laws that prohibit discrimination on the basis of race, color, national origin, age, disability, sex, or language. Connection Dental Network makes decisions in a nondiscriminatory manner. Providing race, ethnicity or language information is optional.

Please fill out as shown on provider license.

License and identification numbers PLEASE LIST ALL STATE LICENSES YOU HAVE HELD, CURRENT DEA and SDC *IF NONE, CONSIDERED WAIVED

License and identification numbers (attach additional pages if necessary)

State	License number	License status		Federal DEA number	DEA Exp (MM/YY)			State Drug Certificate number	SDC status		
		Active	Inactive		Active - Exp Date MM/YY	In Process MM/YY	*No DEA		Active	Inactive	N/A

- You must have at least one active state license to apply to join this network.
- Complete one line for each state license you currently have or have ever held.

PLEASE INCLUDE ALL OF YOUR CURRENT AND PREVIOUS STATE LICENSES ON THIS TABLE AND ATTACH A PAGE, IF NEEDED.

- Must include a federal DEA registration number with current status - OR - select 'No DEA' for each active state license listed on this table.
- Select 'In Process', If in the process of applying or updating the address for your DEA registration.
- *By selecting 'No DEA'* - I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management.

- If you are required to have a state Drug Certificate in order to prescribe or dispense medications in your state, complete this section for each Active state license listed on this table.

YOU MAY CALL OUR CREDENTIALING DEPARTMENT AT (800) 505-8880, EXT 4046, WITH QUESTIONS ABOUT SDCREQUIREMENTS IN YOUR STATE.

Person completing application (if different than provider)	First name:	Last name:
Contact email:		Phone:

Dental specialty IF OTHER THAN GENERAL DENTISTRY

Are you a specialist? Yes ☐ No ☐	If yes, list specialty:	List subspecialty:

American Board Certification THIS IS SEPARATE FROM THE STATE DENTAL BOARD LICENSE/CERTIFICATION

Are you American Board Certified: Yes ☐ No ☐	Date certified:	Valid until:

Please select the type of American Board Certification below:

ABOMS ☐ ABOMP ☐ ABPD ☐ ABE ☐ ABO ☐ ABDPH ☐ ABMS ☐ ABOP ☐ ABOI ☐ ABOMR ☐ ABGD ☐

ABPerio ☐ ABProstho ☐ ABCD ☐ ABDSM ☐ ABDA ☐ None ☐

Professional education IF FOREIGN TRAINED, MUST INCLUDE A COPY OF YOUR DIPLOMA

Name of school:		State:	Country:
Degree:	Graduation date:	Phone:	

Professional training – internship/residency/fellowship IF APPLICABLE

Training institute 1:	Start date:	City:	State:
Phone:	Date completed:	Type of training/specialty:	
Program: Internship ☐ Residency ☐ Fellowship ☐		Was the program successfully completed? Yes ☐ No ☐	
Training institute 2:	Start date:	City:	State:
Phone:	Date completed:	Type of training/specialty:	
Program: Internship ☐ Residency ☐ Fellowship ☐		Was the program successfully completed? Yes ☐ No ☐	
Training institute 3:	Start date:	City:	State:
Phone:	Date completed:	Type of training/specialty:	
Program: Internship ☐ Residency ☐ Fellowship ☐		Was the program successfully completed? Yes ☐ No ☐	

Hospital affiliations IF APPLICABLE. ATTACH ADDITIONAL PAGES IF NEEDED

Do you have hospital affiliations? Yes ☐ No ☐	Hospital name:	
City:	State:	Phone:

Professional liability claims history PLEASE INCLUDE THE LAST 5 YEARS OF ALL PROFESSIONAL LIABILITY CASES

Number of cases settled:	Number of cases that resulted in adverse judgment against dentist:

Five-year dental employment history INCLUDE YOUR CURRENT PRACTICE LOCATION(S) AND ATTACH EXTRA PAGES*, IF NEEDED

Start date	End date	Employer name	City	State

**If you attach extra pages of Dental Employment history, be sure the information is up to date, and initial and date the pages before sending.*

If you have a gap of 180 days or greater between your initial state licensure date and your first dental employment date; -OR- if you have a gap in dental employment history of 180 days or greater during the last 5 years; you must include an explanation for each gap.

Gap start date	Gap end date	Reason for gap if 180 days or greater

**If you attach extra pages of Dental Employment history, be sure the information is up to date, and initial and date the pages before sending.*

If you acquired your initial state license within the last 5 years and have less than 5 years of dental employment history, complete this section.	Initial state of licensure:	Initial state licensure date:

Current practice and office information 1

Office name 1:		Start date:	Part time ☐ Full time ☐
Phone number:		Fax number:	
Physical address 1:	City:	State:	ZIP:
Location affiliated with dental group? Yes ☐ No ☐	Group name:	NPI 2 (organization):	
Location email:			
Office only email:			
What is the best way to reach you? Phone ☐ Email ☐ Fax ☐			
Tax ID name:		Tax ID:	
Is this location an Essential Community Provider? Yes ☐ No ☐		Indian Health Services location? Yes ☐ No ☐	

Complete these fields if different from physical address 1:

Billing or remit address			Mailing address	
Billing city	Billing state	Zip	Mailing city	
Billing phone	Billing fax	Pay to name	Mailing state	Zip

Office 1 services

Accepts new patients	Yes ☐ No ☐	Evening hours:	Yes ☐ No ☐
Medicare patients?	Yes ☐ No ☐	Include in Directory:	Yes ☐ No ☐
Medicaid patients?	Yes ☐ No ☐	Does this location offer Teledentistry:	Yes ☐ No ☐
Handicap access?	Yes ☐ No ☐	*If yes*, what platform is utilized?	
Are there any changes that affect your availability to patients?	Yes ☐ No ☐	What form of Teledentistry is performed? Asynchronous – Store & Forward Indirect Conference ☐ Synchronous – Live Audio/ Video Conference ☐	
Same day appointments?	Yes ☐ No ☐		
Difficult to schedule new patients?	Yes ☐ No ☐	Do you provide dental services via Mobile Dentistry	Yes ☐ No ☐
24/7 coverage?	Yes ☐ No ☐	If yes, what city & state does the Mobile Dentistry provide service in?	
Patient age limit?	Min age: Max age:	What services do you perform via the Mobile Dentistry?	
Weekend hours:	Yes ☐ No ☐	Diagnostic ☐ Preventative ☐ Restorative ☐ Other ☐	
Languages spoken by staff, other than English:		Where is the Mobile Dentistry service performed? Off-site patient/customer location ☐ Mobile Dentistry vehicle ☐	

Office Hours	Mon		Tues		Wed		Thurs		Fri		Sat		Sun	

Sedation/General Anesthesia credentialing requirements

1. Is sedation and/or general anesthesia administered in your practice location? (If no, do not complete the Sedation/Anesthesia Information.)	Yes ☐ No ☐
2. Do you administer sedation and/or general anesthesia? (If yes, please complete questions 3 through 6. If no, skip to question 5 and 6.)	Yes ☐ No ☐
3. Do you have current and valid state issued permits to administer anesthesia?	Yes ☐ No ☐

4. Please check and list all permits that you maintain and apply to your licensure in the state you are applying for:

Deep Sedation/General Anesthesia Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Moderate/Conscious sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Minimal sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Pediatric Moderate/Conscious Sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Nitrous Oxide Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Other permit type:	Permit/License #:
Expiration date:	State:

5. Do you have healthcare clinicians (DDS/DMD, MD, CRNA) providing sedation/anesthesia on patients you are treating at your practice locations?	Yes ☐ No ☐
6. Please confirm that you comply with and have verified that those providing sedation/general anesthesia on your patients comply with your state's requirements regarding equipment, supplies, and training, which includes arranging for and ensuring the presence of required personnel who will assist in administering sedation and general anesthesia in your office.	Yes ☐ No ☐

Credentialing contact information

Contact name:	Credentialing email:
Phone number:	Fax number:

Current practice and office information 2

Office name 2:		Start date:	Part time ☐ Full time ☐
Phone number:		Fax number:	
Physical address 2:	City:	State:	ZIP:
Location affiliated with dental group? Yes ☐ No ☐	Group name:	NPI 2 (organization):	
Location email:			
Office only email:			
What is the best way to reach you? Phone ☐ Email ☐ Fax ☐			
Tax ID name:		Tax ID:	
Is this location an Essential Community Provider? Yes ☐ No ☐		Indian Health Services location? Yes ☐ No ☐	

Complete these fields if different from physical address 2

Billing or remit address			Mailing address
Billing City, State, Zip			Mailing City, State, Zip
Billing phone	Billing fax		Pay to name

Office 2 services

Accepts new patients	Yes ☐ No ☐	Evening hours:	Yes ☐ No ☐
Medicare patients?	Yes ☐ No ☐	Include in Directory:	Yes ☐ No ☐
Medicaid patients?	Yes ☐ No ☐	Does this location offer Teledentistry:	Yes ☐ No ☐
Handicap access?	Yes ☐ No ☐	*If yes*, what platform is utilized?	
Are there any changes that affect your availability to patients?	Yes ☐ No ☐	What form of Teledentistry is performed? Asynchronous – Store & Forward Indirect Conference ☐ Synchronous – Live Audio/ Video Conference ☐	
Same day appointments?	Yes ☐ No ☐		
Difficult to schedule new patients?	Yes ☐ No ☐	Do you provide dental services via Mobile Dentistry	Yes ☐ No ☐
24/7 coverage?	Yes ☐ No ☐	If yes, what city & state does the Mobile Dentistry provide service in?	
Patient age limit?	Min age: Max age:	What services do you perform via the Mobile Dentistry?	
Weekend hours:	Yes ☐ No ☐	Diagnostic ☐ Preventative ☐ Restorative ☐ Other ☐	
Languages spoken by staff, other than English:		Where is the Mobile Dentistry service performed? Off-site patient/customer location ☐ Mobile Dentistry vehicle ☐	

Office Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Sedation/General Anesthesia credentialing requirements

1. Is sedation and/or general anesthesia administered in your practice location? (If no, do not complete the Sedation/Anesthesia Information.)	Yes ☐ No ☐
2. Do you administer sedation and/or general anesthesia? (If yes, please complete questions 3 through 6. If no, skip to question 5 and 6.)	Yes ☐ No ☐
3. Do you have current and valid state issued permits to administer anesthesia?	Yes ☐ No ☐

4. Please check and list all permits that you maintain and apply to your licensure in the state you are applying for:

Deep Sedation/General Anesthesia Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Moderate/Conscious sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Minimal sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Pediatric Moderate/Conscious Sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Nitrous Oxide Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Other permit type:	Permit/License #:
Expiration date:	State:

5. Do you have healthcare clinicians (DDS/DMD, MD, CRNA) providing sedation/anesthesia on patients you are treating at your practice locations?	Yes ☐ No ☐
6. Please confirm that you comply with and have verified that those providing sedation/general anesthesia on your patients comply with your state's requirements regarding equipment, supplies, and training, which includes arranging for and ensuring the presence of required personnel who will assist in administering sedation and general anesthesia in your office.	Yes ☐ No ☐

Credentialing contact information

Contact name:	Credentialing email:
Phone number:	Fax number:

Current practice and office information 3

Office name 3:		Start date:	Part time ☐ Full time ☐
Phone number:		Fax number:	
Physical address 3:	City:	State:	ZIP:
Location affiliated with dental group? Yes ☐ No ☐	Group name:	NPI 2 (organization):	
Location email:			
Office only email:			
What is the best way to reach you? Phone ☐ Email ☐ Fax ☐			
Tax ID name:		Tax ID:	
Is this location an Essential Community Provider? Yes ☐ No ☐		Indian Health Services location? Yes ☐ No ☐	

Complete these fields if different from physical address 3

Billing or remit address			Mailing address	
Billing city	Billing state	Zip	Mailing City	
Billing phone	Billing fax	Pay to name	Mailing State	Zip

Office 3 services

Accepts new patients	Yes ☐ No ☐	Evening hours:	Yes ☐ No ☐
Medicare patients?	Yes ☐ No ☐	Include in Directory:	Yes ☐ No ☐
Medicaid patients?	Yes ☐ No ☐	Does this location offer Teledentistry:	Yes ☐ No ☐
Handicap access?	Yes ☐ No ☐	*If yes*, what platform is utilized?	
Are there any changes that affect your availability to patients?	Yes ☐ No ☐	What form of Teledentistry is performed? Asynchronous – Store & Forward Indirect Conference ☐ Synchronous – Live Audio/ Video Conference ☐	
Same day appointments?	Yes ☐ No ☐		
Difficult to schedule new patients?	Yes ☐ No ☐	Do you provide dental services via Mobile Dentistry	Yes ☐ No ☐
24/7 coverage?	Yes ☐ No ☐	If yes, what city & state does the Mobile Dentistry provide service in?	
Patient age limit?	Min age: Max age:	What services do you perform via the Mobile Dentistry?	
Weekend hours:	Yes ☐ No ☐	Diagnostic ☐ Preventative ☐ Restorative ☐ Other ☐	
Languages spoken by staff, other than English:		Where is the Mobile Dentistry service performed? Off-site patient/customer location ☐ Mobile Dentistry vehicle ☐	

Office Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Sedation/General Anesthesia credentialing requirements

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2. Do you administer sedation and/or general anesthesia? (If yes, please complete questions 3 through 6. If no, skip to question 5 and 6.)	Yes ☐ No ☐
3. Do you have current and valid state issued permits to administer anesthesia?	Yes ☐ No ☐

4. Please check and list all permits that you maintain and apply to your licensure in the state you are applying for:

Deep Sedation/General Anesthesia Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Moderate/Conscious sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Minimal sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Pediatric Moderate/Conscious Sedation (all types) Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Nitrous Oxide Yes ☐ No ☐	Permit/License #:
Expiration date:	State:
Other permit type:	Permit/License #:
Expiration date:	State:

5. Do you have healthcare clinicians (DDS/DMD, MD, CRNA) providing sedation/anesthesia on patients you are treating at your practice locations?	Yes ☐ No ☐
6. Please confirm that you comply with and have verified that those providing sedation/general anesthesia on your patients comply with your state's requirements regarding equipment, supplies, and training, which includes arranging for and ensuring the presence of required personnel who will assist in administering sedation and general anesthesia in your office.	Yes ☐ No ☐

Credentialing contact information

Contact name:	Credentialing email:
Phone number:	Fax number:

Professional questions and attestation FOR EACH "YES" RESPONSE, PLEASE INCLUDE A DETAILED WRITTEN EXPLANATION ALONG WITH THIS FORM IF A QUESTION IS NOT APPLICABLE TO YOU. PLEASE MARK "NO" FOR EACH RESPONSE	
1. Has your license(s) to practice in any jurisdiction(s), whether completed or still pending, been lost, denied, limited, suspended, revoked, not renewed; or have you been placed under probation, subjected to disciplinary action, or have you voluntarily relinquished any item in anticipation of any of these actions since original licenser date?	Yes ■ No ☐
2. Has your professional liability insurance ever been denied, suspended, revoked, canceled or not renewed?	Yes ☐ No ☐
3. Has your federal DEA or any State Drug Certificate Registrations ever been lost, denied, suspended, canceled, or subjected to any disciplinary action?	Yes ☐ No ☐
4. Has your status as a provider, or membership with any professional organization, ever been lost, denied, suspended, disciplined, canceled, or sanctioned; or are you currently under investigation by any municipal, state, federal or any other governmental agency, or any HMO, PPO or other prepaid health plan (e.g. state or Federal Medicare or Medicaid)?	Yes ☐ No ☐
5. Are your privileges or memberships at any hospital or institution (military service) currently under investigation or have they ever been lost, denied, suspended, reduced, disciplined, or not renewed?	Yes ☐ No ☐
6. Have you ever been prevented from performing any procedures within the scope of privileges and duties as a dental care provider?	Yes ☐ No ☐
7. Do you currently, or have you ever, engaged in the unlawful use of drugs, including the improper use of prescription drugs?	Yes ☐ No ☐
8. Do you have any felony or misdemeanor charges pending against you other than a traffic violation, or have you ever been convicted of – or pleaded guilty or nolo contendere to – a felony or a misdemeanor?	Yes ☐ No ☐
9. Have you ever been involved, or are you currently involved in ANY claims/lawsuits, settlements or judgments (other than divorce or custody)?	Yes ☐ No ☐
10. Are you currently practicing WITHOUT or with EXPIRED Professional Liability/Malpractice Insurance?	Yes ☐ No ☐
11. Do you have any conditions that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of members?	Yes ☐ No ☐

Authorization, PLEASE SIGN AND DATE

Practitioner hereby certifies that the information provided on the Credentialing Application is true and complete and correct to the best of his or her knowledge. Practitioner hereby authorizes GEHA and its authorized representatives to contact individuals and organizations to obtain information pertaining to his or her qualifications for the credentialing and any subsequent recredentialing processes. Practitioner 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, Attestation, or Recredentialing Application process. GEHA will treat information in the Credentialing Application, Attestation, or Recredentialing Application that is not publicly available as confidential, unless disclosure is required by law, regulation or an accrediting organization. Practitioner agrees to advise GEHA of any changes in the information provided on the Credentialing Application, Attestation, or Recredentialing Application. Practitioner understand that submission of the Credentialing Application, Attestation, or Recredentialing Application does not guarantee participation or continued participation in the Connection Dental Network. A photocopy of this page shall be considered a valid authorization.

Further, Practitioner acknowledges that as part of the application process, he/she states that they (1) have reviewed Fraud, Waste, and Abuse training within the past 12 months and will review the GEHA Code of Ethical Business Conduct within 90 days of the Effective Date of the GEHA Participating Provider Agreement or (2) have read the (a) overview of the GEHA Compliance Program (b) GEHA Code of Ethical Business Conduct and (c) information on fraud, waste, and abuse, which includes my obligation to report compliance/ethics and fraud, waste and abuse concerns to GEHA. Items A, B, and C, as referenced above, can be found under the Resources Tab, www.connectiondental.com.

This space is intentionally left blank.

If my application is approved and I enter into an Individual Participating Provider Agreement with GEHA, I understand and agree to annually review the items referenced above as (a), (b), and (c) above and abide by the following compliance obligations:

1) That employees will review the materials referenced above and will be advised to report any compliance/ethics and fraud, waste and abuse concerns.
2) That any downstream entities with whom I contract for services relative to my dental practice will also be provided the materials referenced above.
3) That employees have been screened against both the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and exclusion records accessed through the System for Award Management (SAM), the system that consolidated the capabilities of CCR/FedReg, ORCA and EPLS, formally known as GSA, prior to hire or contract and monthly thereafter. Excluded individuals will be removed from providing services to Medicare Advantage plan members immediately and reported to GEHA.

Practitioner signature:	Date (required):
Printed name:	Tax ID#:
Additional contact name:	Phone:
NPI 1 (Individual):	

Connection Dental Network
PO Box 6707 | Lee's Summit, MO 64064-6707
800.505.8880, option 2
cdnapplications@geha.com | connectiondental.com