Initial Dental Credentialing Application

PO Box 91110
Sioux Falls, SD 57109
(605) 328-6800 • 1-800-752-5863
Fax: (605) 328-6840
sanfordhealthplan.com

SANFORD
Dental Network

Applicant Name_____
Last *First* *Middle* *Suffix* *Title*

Credentialing Contact Information

Practice Name _____

Credentialing Contact_____

Address, City, State, Zip _____

Phone Number _____ Fax Number _____ E-mail _____

Instructions

The initial credentialing application and attachments should be typed, legibly printed in black ink, or electronically generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Please mark all non-applicable sections with N/A. **Please Note: Incomplete applications will be returned to you and will significantly delay your credentialing process.**

Checklist *(please complete)*
Current copies of the following documents must be submitted with this application. If your application for DEA and/or malpractice insurance are pending, please forward application and send those documents as soon as possible.

- ☐ Diploma (if educated outside of U.S. or Canada)
- ☐ Malpractice Litigation and Professional Complaints Form (if applicable)
- ☐ Malpractice liability insurance documentation
- ☐ South Dakota Controlled Substance Certificate (or any other state if applicable)
- ☐ Current State License

In addition, please verify that you have:

- ☐ Provided complete street addresses, phone and fax wherever indicated, including current, past and pending employment
- ☐ Designated dates by month, day and year time frames
- ☐ Explained all gaps of greater than sixty days in chronology
- ☐ Answered all of the Disclosure Questions and enclosed explanations for affirmative answers
- ☐ Signed and dated the Authorization and Release

All Information Must Be Printed in Black Ink, Typed or Electronically Generated

Personal Data

Name_____
Last *First* *Middle* *Suffix* *Title*

Maiden/Former/Other Name(s)_____ Gender: ☐ Male ☐ Female

Date of Birth_____/_____/_____ Birthplace (city/state/country)_____

Social Security Number _____ U.S. Citizen: ☐ Yes ☐ No

Current Home Address:_____
Street *City/State/County/Country* *Zip Code*

NPI_____ Email Address _____

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language?

☐ Yes ☐ No If yes, specify languages _____

Specialty in which care will be provided_____

Primary or Pending Practice Location

Primary Practice Location/Clinic Name (Legal Name)_____

Physical Address_____
Street *City/State/Country* *Zip Code*

Mailing Address_____
Street *City/State/Country* *Zip Code*

Clinic/Practice Website Address_____

Hours of Operation

Monday : AM to : PM ☐ Closed

Tuesday : AM to : PM ☐ Closed

Wednesday : AM to : PM ☐ Closed

Thursday : AM to : PM ☐ Closed

Friday : AM to : PM ☐ Closed

Saturday : AM to : PM ☐ Closed

Sunday : AM to : PM ☐ Closed

Office Phone Number _____ Fax Number_____

Currently practicing at this location? ☐ Yes ☐ No Start Date:_____

Billing/Contact Information (If multiple billing locations and information, please attach a separate sheet)

Federal Tax ID Number _____ Billing NPI _____

Remit Payment to _____

Address_____
Street *City/State/Country* *Zip Code*

Contact Name_____ E-mail Address_____

Phone Number _____ Fax Number _____

Additional Practice Location(s) - If additional space is required, attach a separate sheet.

1. Other Practice Name (Legal Name)_____ Phone Number_____

   Physical Address_____
   Street *City/State/Country* *Zip Code*

   Mailing Address_____
   Street *City/State/Country* *Zip Code*

   Clinic/Practice Website Address_____

   Hours of Operation

   Monday ___:___ AM to ___:___ PM ☐ Closed

   Tuesday ___:___ AM to ___:___ PM ☐ Closed

   Wednesday ___:___ AM to ___:___ PM ☐ Closed

   Thursday ___:___ AM to ___:___ PM ☐ Closed

   Friday ___:___ AM to ___:___ PM ☐ Closed

   Saturday ___:___ AM to ___:___ PM ☐ Closed

   Sunday ___:___ AM to ___:___ PM ☐ Closed

   E-mail Address_____ Fax Number_____

   Phone Number_____ Currently practicing at this location? ☐ Yes ☐ No Start Date_____

   If yes, will you continue to practice at this location? ☐ Yes ☐ No If no, last date of employment_____

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2. Other Practice Name (Legal Name)_____ Phone Number_____

   Physical Address_____
   Street *City/State/Country* *Zip Code*

   Mailing Address_____
   Street *City/State/Country* *Zip Code*

   Clinic/Practice Website Address_____

   Hours of Operation

   Monday ___:___ AM to ___:___ PM ☐ Closed

   Tuesday ___:___ AM to ___:___ PM ☐ Closed

   Wednesday ___:___ AM to ___:___ PM ☐ Closed

   Thursday ___:___ AM to ___:___ PM ☐ Closed

   Friday ___:___ AM to ___:___ PM ☐ Closed

   Saturday ___:___ AM to ___:___ PM ☐ Closed

   Sunday ___:___ AM to ___:___ PM ☐ Closed

   E-mail Address_____ Fax Number_____

   Credentialing Contact_____ Phone Number_____

   Currently practicing at this location? ☐ Yes ☐ No Start Date_____

   If yes, will you continue to practice at this location? ☐ Yes ☐ No If no, last date of employment_____

Dental School

From _____/_____/_____ (*Month, day and year required)* Institution Name_____

To _____/_____/_____ Degree Received: ☐DMD ☐DDS ☐Other_____

Address_____
Street *City/State/Country* *Zip Code*

Phone Number_____ Fax Number_____

From _____/_____/_____ Institution Name_____

To _____/_____/_____ Degree Received: ☐DMD ☐DDS ☐Other_____

Address_____
Street *City/State/Country* *Zip Code*

Phone Number_____ Fax Number_____

Residency/Post-Graduate/ Training - If additional space is required, attach a separate sheet.

From _____/_____/_____ (*Month, day and year required)* Institution Name_____

To _____/_____/_____ Type of Program/Specialty_____

Completed Training: ☐Yes ☐No If no, expected completion date_____

If not successfully completed, explain_____

Program Director_____

Address_____
Street *City/State/Country* *Zip Code*

Phone Number_____ Fax Number_____

From _____/_____/_____ (*Month, day and year required)* Institution Name_____

To _____/_____/_____ Type of Program/Specialty_____

Completed Training: ☐Yes ☐No If no, expected completion date_____

If not successfully completed, explain_____

Program Director_____

Address_____
Street *City/State/Country* *Zip Code*

Phone Number_____ Fax Number_____

Chronological Employment/Practice History

Include Military Service. You may attach a separate sheet for additional employments if needed. **Chronological listing [day/month/year] of employment/practice history since completion of your post-graduate training.** List all experience, including military service and public health, time out of dental practice in pursuit of other business or professional activities, sabbaticals, parenting, personal travel, personal crisis, etc. ***Leave no gaps in chronology.***

Month, day and year required

From: _____/_____/_____ Organization Name/Activity ____

To _____/_____/_____ Reason for leaving ____

Contact Name ____

Address ____
Street *City/State/Country* *Zip Code*

Phone Number ______________________________ Fax Number ______________________________

Clinic still open? ☐Yes ☐No If no, attach sheet with address and phone number of person who can verify your time there.

From: _____/_____/_____ Organization Name/Activity ____

To _____/_____/_____ Reason for leaving ____

Contact Name ____

Address ____
Street *City/State/Country* *Zip Code*

Phone Number ______________________________ Fax Number ______________________________

Clinic still open? ☐Yes ☐No If no, attach sheet with address and phone number of person who can verify your time there.

From: _____/_____/_____ Organization Name/Activity ____

To _____/_____/_____ Reason for leaving ____

Contact Name ____

Address ____
Street *City/State/Country* *Zip Code*

Phone Number ______________________________ Fax Number ______________________________

Clinic still open? ☐Yes ☐No If no, attach sheet with address and phone number of person who can verify your time there.

Explain gaps/interruptions of greater than sixty days to practice of medicine/professional practice *(if additional space is required, attach a separate sheet):*

From: _____/_____/_____ Explain ____

To: _____/_____/_____ ____

From: _____/_____/_____ Explain ____

To: _____/_____/_____ ____

Primary Hospital Affiliation - pertinent to Primary or Pending Practice Location

If no hospital admitting privileges, describe method/coverage for continuity of care. Please provide covering physician's name, if applicable.

_____

_____

Month, day and year required

From _____/_____/_____ Facility Name_____

To _____/_____/_____ Type/category of privilege/affiliation (active, courtesy, etc.)_____

Admitting Privileges: ☐Yes ☐No Application Pending:☐

Department Name_____ Department Chairperson _____

Address_____
Street *City/State/Country* *Zip Code*

Phone Number_____ Fax Number _____

Other Hospital Affiliations - Present and past affiliations beginning with most recent.

Month, day and year required. If hospital changed name, list current name and address.

From _____/_____/_____ Facility Name_____

To _____/_____/_____ Type/category of privilege/affiliation (active, courtesy, etc.)_____

Admitting Privileges: ☐Yes ☐No Application Pending:☐

Department Name_____ Department Chairperson _____

Address_____
Street *City/State/Country* *Zip Code*

Phone Number_____ Fax Number _____

From _____/_____/_____ Facility Name_____

To _____/_____/_____ Type/category of privilege/affiliation (active, courtesy, etc.)_____

Admitting Privileges: ☐Yes ☐No Application Pending:☐

Department Name_____ Department Chairperson _____

Address_____
Street *City/State/Country* *Zip Code*

Phone Number_____ Fax Number _____

Specialty/Subspecialty Certification

Certifying Board	Specialty/Subspecialty	Date Certified	Date Recertified	Expiration Date	Cert. Pending
		___/___/___	___/___/___	___/___/___	☐
		___/___/___	___/___/___	___/___/___	☐

Licensure - List all past, current and pending professional licenses.

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

Drug Enforcement Administration Registration

Note: Address on DEA certificate must be in state where you are/will be practicing as applicable to this application.

DEA Number_____ State_____ Expiration Date _____/_____/_____

State CSR_____ State_____ Expiration Date_____/_____/_____

If you do not maintain a DEA certificate, please explain: _____

☐ Not applicable to practice

☐ DEA certificate pending; date application submitted to DEA _____ /_____/_____ *(Attach copy of application)*

Liability Insurance - Insurance Carrier for Primary and Pending Practice Location

Enclose a copy of professional liability insurance coverage (e.g., face sheet/verification of self-insurance) for primary practice location to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered. If additional space is required, attach a separate sheet.

Coverage dates:

From _____/_____/_____ Insurance Carrier Name_____

To _____/_____/_____ Name in which policy issued_____

☐ Certificate Pending Policy number_____ Expiration Date _____/_____/_____

Amount of coverage (per occurrence/aggregate)_____

Disclosure Questions for Initial Credentialing

Please provide a complete explanation if any of the following questions are answered in the affirmative. Use a separate sheet to continue, if necessary.

1. ☐Yes ☐No Has your professional license or registration ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending?

_____

2. ☐Yes ☐No Has your professional license or registration ever been investigated or is it currently being investigated and, if so, what were the results?

_____

3. ☐Yes ☐No Has your DEA registration ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?

_____

4. ☐Yes ☐No Has your membership, participation, clinical privileges, or employment ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

_____

5. ☐Yes ☐No Have you ever voluntarily relinquished your membership, participation, clinical privileges or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?

_____

6. ☐Yes ☐No Have you ever involuntarily relinquished your membership, participation, clinical privileges or request for privileges, employment, professional license or registration?

_____

7. ☐Yes ☐No Has your membership or fellowship in any professional organization or your specialty board certification ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?

_____

8. ☐Yes ☐No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?

_____

9. ☐Yes ☐No Has your certificate or participation in any private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

_____

10. ☐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, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense?

_____

11. ☐Yes ☐No Have you ever been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment with a patient, co-worker, or other?

_____

12. ☐Yes ☐No Have you ever had any professional liability claims or lawsuits brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? If yes, please complete the enclosed Malpractice Litigation and Professional Complaints Addendum. You may be asked for additional information by individual organizations.

_____

13. ☐Yes ☐No Has your professional liability carrier ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?

_____

14. ☐Yes ☐No Have you ever practiced within your profession without professional liability insurance?

_____

15. ☐Yes ☐No Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in your area of practice without posing a health or safety risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

_____

16. ☐Yes ☐No Does your use (or have you been told that your use) of alcohol or drugs affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice without posing a health risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

_____

17. ☐Yes ☐No Are you currently using illegal drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

_____

Notice of Applicant's Rights

You may review your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable state laws. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to add information to your application.

Signature and Date

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed.

Signature _____ Date _____

Printed Name _____

Attestation, Authorization and Release – Please read carefully before signing.

I understand and acknowledge that, as an applicant for membership, participation and/or clinical privileges (hereinafter, referred to as "Participation") at Sanford Health Plan (hereafter referred to as Entity), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by the Entity for Participation.

I further acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of the Entity and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation.

I further understand and acknowledge that the Entity, its designated agent(s) and/or other authorized representatives, including, without limitation, the Entity's designated professional credentials verification organization (CVO), collectively referred to as "Agents", will investigate the information in this Application. By submitting this Application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Entity and its Agents as follows:

1. Authorization of Investigation and Release of Information Concerning Application for Participation. I authorize the Entity and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation and authorize such third parties to release such information to the Entity and its Agents.
2. Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary Information about any disciplinary action taken against me to the Entity and/or its Agents, including, without limitation, the CVO, and as otherwise may be required by law. I hereby further authorize the CVO to release Disciplinary Information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organizations, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition my Participation or impose a corrective action plan; (ii) any other disciplinary actions involving me including but not limited to discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.
3. Release from Liability. I hereby further release from liability the Entity and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunities provided by law for peer review activities.

   I understand that communication regarding my application may occur via email.I understand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation at the Entity, or I am a member of Entity's medical or health care staff, or a participating provider of the Entity. I agree to execute another consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide another consent may be grounds for termination or discipline of the Participant by the Entity in accordance with the applicable bylaws, rules and regulations, and requirements of the Entity. I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Entity and its Agents are done to achieve, maintain and improve quality patient care.
   All information provided by me in the Application is true to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of Participation. I understand and acknowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original.

Signature _____ Date _____

Printed Name _____

Malpractice Litigation and Professional Complaints Addendum Confidential Information

If you answered yes to disclosure question #12 on Current Disclosure question page, please complete the following form. For each lawsuit or complaint, please furnish the following and attach a copy of the complaint including your response to the complaint and level of participation. It is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc.) of your response. You may choose to have your attorney complete this form. Please make additional copies of this form if needed.

Month/Year of incident _____/_____ Reported to the NPDB: ☐ Yes ☐ No

Where incident occurred_____ Facility Name_____

Address: City_____ State_____ Zip Code_____

Describe the nature of incident (Complaint, Allegation)

_____

_____

_____

_____

_____

Provide a narrative description of your participation/level of care_____

_____

_____

Outcome of incident

Concluded with no payments only:

☐ Dropped/Closed Date_____/_____
☐ Verdict for you Date_____/_____
☐ Dismiss with prejudice? Date_____/_____
☐ Dismissed w/out prejudice? Date_____/_____

Concluded with payments only:

☐ Verdict for plaintiff Date_____/_____ Amount_____
☐ Settled Date_____/_____ Amount _____
☐ Pending *(date of occurrence)* Date_____/_____

Represented by Legal Counsel for this claim/malpractice lawsuit? ☐ Yes ☐ No If yes, list name and address of counsel.

Name_____ Phone Number_____

Address_____

Insurance company or employer that provided coverage for this claim:

Address: _____

Phone Number:_____ Policy Number:_____

Print Name_____ **Phone Number**_____

Signature_____ **Date** _____

Addendum One - Confidential Health Status Information

In order to process your application, it is necessary to inquire about your health status.
The purpose of this form is to confirm whether you are capable of performing the duties and responsibilities of appointment and exercising the clinical privileges requested safely and competently.

Complete this questionnaire and return to the Central Verification Office. We will place this form in a sealed Confidential Health Status envelope for each facility you are applying and send it to those medical staff offices. The envelope will not be opened until *after* the Medical Executive Committee has taken initial action on your application and evaluated your professional qualifications.

1. ☐Yes ☐No Do you have any physical or mental condition that could affect your ability to exercise the clinical privileges requested and perform the duties of staff appointment or that would require an accommodation in order for you to exercise the privileges requested safely and competently?
2. ☐Yes ☐No Have you ever had any problems with alcohol or drug dependency?
3. ☐Yes ☐No Are you currently taking any medication that may affect either your clinical judgment or motor skills?
4. ☐Yes ☐No Are you currently under any limitations concerning your activities or work load?

If the answer is "yes" to any question, please explain and submit a report from your treating physician specifically addressing how the condition may affect your ability to exercise the privileges you have requested or the duties of staff appointment. Please also explain any proposed accommodation.

Certification
I certify that my staff appointment and clinical privileges are conditional upon my demonstrating that I am capable of exercising my privileges safely and competently and performing the duties and essential functions of staff appointment. I understand that the burden is on me to request any proposed accommodations and to justify its reasonableness. By my signature below, I hereby certify that all the information provided above is true, complete and correct. I agree to inform the hospital and supplement, as necessary, should any statement of the information contained above, although true when made, becomes untrue do to a change in circumstances of discovery of new information. Any falsification to this health status questionnaire is grounds for termination.

_____
Printed Name

_____ _____
Signature Date

Addendum Two - NCQA Questions

Sanford Health Plan requests the following information.

Access and Availability Questions:

1. ☐ Yes ☐ No Are you currently accepting new patients into your practice?
2. ☐ Yes ☐ No Are you willing, in the future, to accept new patients?
3. ☐ Yes ☐ No Does the office have wheelchair or handicapped access?

Ethnicity Question:

In an effort to fulfill a NCQA requirement, we are requesting the race/ethnicity of the practitioners in our network. This data will be collected and analyzed to determine if we are meeting the cultural needs of our member population. Please check your race/ethnicity below.

☐ African American/Black
☐ Asian
☐ Caucasian/White
☐ Hispanic/Latino/White
☐ Hispanic/Latino/Black
☐ Hispanic/Latino/Declined
☐ Middle Eastern
☐ Native American
☐ Native Hawaiian/Pacific Islander
☐ More than one race
☐ Declined
☐ Unavailable/Unknown
☐ Other _____