ENVOLVE DENTAL

Provider Credentialing Application

envolve Benefit Options

INSTRUCTIONS:

If you have attested your CAQH credentialing profile within the last 90 days and have granted access to Envolve, complete **ONLY** the CAQH ENROLLMENT section below **AND** sign the Standard Authorization, Attestation and Release Form (located on page 5). You will still need to attach a W-9, Disclosure of Ownership and all state-required forms with your application.

If you do not have a CAQH credentialing profile, proceed to the PROVIDER INFORMATION section below and complete the application in its entirety.

CAQH ENROLLMENT: YES NO

(IF YES, PLEASE COMPLETE PROVIDER NAME, NPI AND DO NOT FORGET TO SIGN LAST PAGE OF APPLICATION. IF NO, PLEASE COMPLETE ENTIRE APPLICATION.)

CAQH ID | LAST | FIRST | MIDDLE (PROVIDER NAME) | NPI #

PROVIDER INFORMATION:

***PROVIDER NAME:** LAST FIRST MIDDLE **SUFFIX (JR, III):**

***PROVIDER TYPE:** ☐DDS ☐DMD ☐RDH ☐MD

***SPECIALITY TYPE:** ☐ENDODONTIST ☐ORTHODONTIST ☐ORAL/MAXILLOFACIAL SURGEON ☐PEDODONTIST ☐PROSTHODONTIST ☐PERIODONTIST ☐ANESTHESIOLOGIST

***HAVE YOU EVER USED ANOTHER NAME?** ☐YES ☐NO **(IF YES, PLEASE LIST THE OTHER NAME(S) USED AND THEIR DATES OF USE BELOW.)**

NAME: LAST FIRST MIDDLE SUFFIX (JR, III):

DATES OF USE: STARTED USING NAME STOPPED USING NAME

***GENDER:** ☐MALE ☐FEMALE ***DATE OF BIRTH:** ***SSN:**

***LANGUAGE(S) SPOKEN?** PRIMARY: SECONDARY: OTHER(S):

PROFESSIONAL INFORMATION:

***NPI#:** ***TAXONOMY CODE:**

***DEA#:** **STATE:** **DATES:** ISSUED EXPIRATION

***DO YOU HAVE CURRENT AND VALID STATE ISSUED PERMITS TO ADMINISTER ORAL, ENTERAL, PARENTERAL, INTRAVENOUS, INHALATION, CONSCIOUS AND/OR PEDIATRIC CONSCIOUS SEDATION?** ☐YES ☐NO

☐ORAL/ENTERAL ☐PARENTERAL ☐INTRAVENOUS ☐INHALATION
☐GENERAL ANESTHESIA ☐CONSCIOUS SEDATION ☐PEDIATRIC SEDATION

***CDS CERTIFICATE #:** **DATES:** ISSUED EXPIRATION

***LICENSE#:** **STATE:** **DATES:** ISSUED EXPIRATION

MEDICAID# (IF APPLICABLE): **STATE:**

MEDICAID MEMBERS ACCEPTED: ☐**CHILDREN** ☐**ADULTS** ☐**BOTH**

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

EDUCATION INFORMATION:

***DENTAL SCHOOL ATTENDED**:

*ADDRESS: *CITY: *STATE:

*ZIP CODE: *TELEPHONE: *FAX:

*DEGREE AWARDED: *START DATE: *END DATE:
GRADUATION

TRAINING (LIST ALL TRAINING PROGRAMS YOU ATTENDED. USE ONE SECTION PER INSTITUTION)

*INSTITUTIONAL/HOSPITAL NAME:

*ADDRESS: *CITY: *STATE:

*ZIP CODE: *TELEPHONE: *FAX:

☐**INTERNSHIP** ☐**RESIDENCY** ☐**FELLOWSHIP** *START DATE: *END DATE:
GRADUATION

***BOARD CERTIFIED:** ☐YES ☐NO **(PLEASE CHECK "NO" IF NOT APPLICABLE. DO NOT LEAVE BLANK.)**

*NAME OF CERTIFYING BOARD: *DATES:
INITIAL CERTIFICATION END (IF APPLICABLE)

CREDENTIALING CONTACT INFORMATION:

(PRIMARY CONTACT IN WHICH WE CAN REACH OUT TO AND SEND/REQUEST DOCUMENTS/ INFORMATION)

***NAME:** ***EMAIL:**
LAST FIRST MIDDLE

*ADDRESS: *CITY: *STATE:

*ZIP CODE: *TELEPHONE: *FAX:

PRIMARY PRACTICE INFORMATION:

***PHYSICIAN GROUP/PRACTICE NAME (DO NOT ABBREVIATE)**:

*ADDRESS: *CITY: *STATE:

*ZIP CODE: *TELEPHONE: *FAX:

*EMAIL: *START DATE:

***PRIMARY TAX ID (ONE ONLY):**

☐GROUP ☐INDIVIDUAL

***OFFICE HOURS**

MON: THURS: SUN:

TUES: FRI:

WED: SAT:

*TAX ID:

*GROUP NPI:

***ACCESS (CHECK ALL THAT APPLY):** ☐HANDICAP ACCESS ☐SPECIAL NEEDS ☐PUBLIC TRANSPORTATION ☐NEW PATIENTS ☐EXISTING PATIENTS

HOSPITAL AFFILIATIONS (IF APPLICABLE):

DO YOU HAVE HOSPITAL PRIVILEGES? ☐YES ☐NO

HOSPITAL NAME:

ADDRESS: CITY: STATE:

ZIP CODE: AFFILIATION DATES:
START END

DEPARTMENT NAME: DEPARTMENT DIRECTOR:

FULL, UNRESTRICTED PRIVILEGES? ☐YES ☐NO **ADMITTING PRIVILEGE STATUS?** ☐YES ☐NO

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

FIVE-YEAR WORK HISTORY:

Please supply a five-year Work History including your **current dental practice location** and any GAPS in employment of six months or longer. Dates must show **Month** and **Year**.

***DENTAL PRACTICE**:
*ADDRESS:
*CITY: *STATE: *ZIP CODE:
*TELEPHONE: *FAX: *EMAIL:
***START DATE:** ***END DATE:**

***DENTAL PRACTICE**:
*ADDRESS:
*CITY: *STATE: *ZIP CODE:
*TELEPHONE: *FAX: *EMAIL:
***START DATE:** ***END DATE:**

DENTAL PRACTICE:
ADDRESS:
CITY: STATE: ZIP CODE:
TELEPHONE: FAX: EMAIL:
START DATE: **END DATE:**

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DENTAL PRACTICE:
ADDRESS:
CITY: STATE: ZIP CODE:
TELEPHONE: FAX: EMAIL:
START DATE: **END DATE:**

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DISCLOSURE QUESTIONS (ALL questions must be answered)

For each "YES" response please include a detailed explanation with this form. Please check "NO" for any questions that are NOT APPLICABLE.

1. In the past five (5) years, have you had any gaps of six (6) months or greater, where you did not work as a practitioner in this current discipline? If "YES," please provide the reason(s) for any gap(s) on a separate page. Please mark "NO," if any gaps occur between education and employment.
   ☐**Yes** ☐**No**
2. Has your license(s) to practice in any jurisdiction(s), whether completed or still pending, ever been denied, limited, suspended, revoked, not renewed, or have you ever been placed under probation, subject to disciplinary action or have you voluntarily relinquished any item in anticipation of any of these actions?
   ☐**Yes** ☐**No**
3. Has your professional liability insurance ever been denied, suspended, canceled, or subjected to any disciplinary action?
   ☐**Yes** ☐**No**
4. Have any of your DEA or State Drug Certificate registrations ever been denied, suspended, canceled, or subjected to any disciplinary action?
   ☐**Yes** ☐**No**
5. Has your status as a provider or membership with any professional organization, ever been denied, suspended, canceled, sanctioned, or subjected to any disciplinary action? Are you currently under investigation by any municipal, state, federal or any other government agency, HMO, PPO or other prepaid health plan? (e.g. Medicare, Medicaid)
   ☐**Yes** ☐**No**
6. Are your privileges or memberships at any hospital or institution (military service) currently under investigation or have they ever been denied, suspended, reduced, disciplined, or not renewed?
   ☐**Yes** ☐**No**
7. Are you prevented from performing any procedures within the scope of privileges and duties as a healthcare provider?
   ☐**Yes** ☐**No**
8. Do you currently, or did you in the last five years, engage in the unlawful use of drugs, including the improper use of prescription drugs?
   ☐**Yes** ☐**No**
9. Do you have any felony or misdemeanor charges pending against you, other than a traffic violation, or have you ever been convicted or pleaded "nolo contendere" to a felony?
   ☐**Yes** ☐**No**
10. Have you been involved, within the last ten years, or are you currently involved in ANY claims/lawsuits, settlements, or judgments (other than divorce or custody)? If YES, please provide detailed information on a separate sheet of paper including: docket # of the case, location of the court, the names of the party plaintiff(s) and defendant(s), description and date(s) of the incidents(s), your involvement, current disposition, and the amount of settlement.
    ☐**Yes** ☐**No**
11. Are you currently practicing WITHOUT, or with and EXPIRED, Professional Liability/Malpractice Insurance?
    ☐**Yes** ☐**No**
12. Have you ever been reported to the National Practitioner's Data Base?
    ☐**Yes** ☐**No**

I hereby make formal application for network participation with **ENVOLVE DENTAL.**

***DOCTOR'S SIGNATURE:** _____ ***DATE:** _____

(No Signature Stamps)

***PRINT NAME:** _____ ***LICENSE #:** _____ ***STATE:** _____

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STANDARD AUTHORIZATION, ATTESTATION AND RELEASE

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, 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 in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise 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 action 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 were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

***DOCTOR'S SIGNATURE:**_____ ***DATE:**

(No Signature Stamps)

***PRINT NAME:**

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