



DENTAL CREDENTIALS VERIFICATION

INSTRUCTIONS: This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

PRACTITIONER/PRACTICE INFORMATION							
NAME (LAST)		(FIRST)		(MIDDLE)		GENDER	
SOCIAL SECURITY NO. (SSN)		PERSONAL NPI NUMBER		PRACTICE NPI NUMBER		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE DATE OF BIRTH _____	
TAXPAYER IDENTIFICATION NUMBER USED: <input type="checkbox"/> SSN or <input type="checkbox"/> EIN (EMPLOYER IDENTIFICATION NUMBER)						DOES YOUR OFFICE COMPLY WITH OSHA/CDC STANDARDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
List # _____							
PRACTICE NAME _____							
PRIMARY OFFICE STREET ADDRESS _____				CITY _____		STATE _____ ZIP _____	
TELEPHONE NUMBER _____			OFFICE FAX NUMBER _____			E-MAIL _____	
DENTAL LICENSURE				BOARD CERTIFICATION			
STATE OF _____		LICENSE NUMBER / EXP. DATE _____		SPECIALTY _____		DATE CERTIFIED/RECERTIFIED _____	
OTHER CERTIFICATIONS (ATTACH CERTIFICATE IF APPLICABLE) Examples Include: ACLS, BLS, ATLS, PALS, NRP, E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.							
TYPE(S): _____				NUMBER(S): _____		EXP. DATE(S): _____	
CURRENT HOSPITAL & OTHER INSTITUTIONAL AFFILIATIONS							
FACILITY NAME: _____				ACTIVE <input type="checkbox"/>		STAFF PRIVILEGES	
				COURTESY <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
PROFESSIONAL LIABILITY							
NAME OF CARRIER _____				POLICY NUMBER _____			
Delta Dental requires a \$500,000 minimum per claim and a \$1 million minimum aggregate amount						EFFECTIVE DATE _____	
LIST YOUR LIMIT PER CLAIM / AGGREGATE AMT: _____						EXPIRATION DATE _____	
PROFESSIONAL STATUS							
If you answer "yes" to any of the following questions, please give full details on a separate sheet of paper.							
						YES	NO
1. Have you had any malpractice claims or suits filed against you?						<input type="checkbox"/>	<input type="checkbox"/>
If yes, did any of these result in a settlement?						<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____							
2. To your knowledge, are you the subject of an investigation or disciplinary action by any licensing board or hospital as of the date of this application?						<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____							
3. Have you had any professional liability insurance denied, canceled or not renewed?						<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____							
4. Have you had any certificate/license by any Board or agency revoked, suspended, voluntarily surrendered, limited or otherwise sanctioned?						<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____							
5. Have you been denied a DEA registration number or been issued a restricted DEA registration?						<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____							

I acknowledge that information relating to this application may be investigated and verified by Delta Dental and/or its Representatives and agree that all information contained herein is true and complete, including my NPI which is a component of the credentialing/recredentialing process.

SIGNATURE _____

DATE _____

DELTA DENTAL REVIEW: _____

REVIEW DATE: _____

Insurance products provided by Oregon Dental Service, doing business as Delta Dental of Alaska.