



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) | |
| SOCIAL SECURITY NO. (SSN) | | PERSONAL NPI NUMBER | | PRACTICE NPI NUMBER | |
| | | | | <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> _____ | |
| 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 | | EMAIL | |
| 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 LIST YOUR LIMIT PER CLAIM / AGGREGATE AMT: | | | | EFFECTIVE DATE | 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 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 by Delta Dental Insurance Company and administered by Oregon Dental Service.