South Carolina

*BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association*

BlueChoice® HealthPlan South Carolina

An independent licensee of the Blue Cross and Blue Shield Association

# DENTAL CREDENTIALING APPLICATION

**We cannot process this Credentialing Application until you complete it in full. Please maintain a copy of this Credentialing Application for your records.**

**Please note that your individual dentist contract is portable and we will apply it to all current locations where you are practicing as identified in this application.**

The information contained in this application will be used by the contracting entity of each participation agreement and for each network you wish to participate in, including those of affiliates.

## The Credentialing Application is complete when:

- ☐ You have signed and dated it
  *(Rubber Stamped and Electronic Signatures Are Not Acceptable)*
- ☐ You have attached current copies of these:
  - ✓ Dental license (provide copies for EVERY state in which you are licensed)
  - ✓ Federal DEA registration for EVERY ENTITY in which the DDS is prescribing controlled substances (or documetnation DEA is pending).
  - ✓ American Board/Specialty Certificate (if applicable)
  - ✓ Professional Liability Insurance Declaration Page for each state in which you practice — showing policy limits, dentist's name, policy number, effective and expiration dates
    - ❍ If expiration date is within weeks of this application, submit updated documentation.
- ☐ For multiple practice locations, please attach a separate sheet with the practice information.
- ☐ A signed contract signature page for the Participating Dental Network. If you need a copy of the Participating Dental Network contract, please email your requests to: Provider.Cert@bcbssc.com.

## Fax completed application, documentation and contract signature page(s) to 803-870-8919.

**Notice of Applicant's Right**

You may review or request the status of 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 credentialing process, we will notify and allow you an opportunity to correct erroneous information submitted by another party within 30 days of submitting your application. This includes information submitted by an outside primary source, such as a professional insurance carrier, state-licensed board and/or the National Practitioner Data Bank and the Healthcare Integrity Protection Data Bank.

**Confidentiality Statement**

Information gathered as part of the credentialing or re-credentialing process is maintained in a confidential manner and will not be communicated or reproduced. The provision is designed to safeguard information and ensure confidentiality.

**DEMOGRAPHICS (Please type or print)** **STATE DENTAL LICENSE #:** _____

Name: _____ DMD DDS Other_____

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Birth Date: ___ ___ / ___ ___ / ___ ___ ___ ___ ☐ Owner ☐ Partner ☐ Associate

Individual NPI: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Gender: ☐ Male ☐ Female

Federal DEA: Do you currently hold a federal DEA registration in each state you prescribe controlled substances?
☐ Yes (Submit copy) ☐ No
If DEA app has been submitted and is PENDING, DDS will not write prescriptions until DEA is finalized.

Languages Spoken Fluently: DDS' Initials:_____

**PRIMARY PRACTICE LOCATION If more than one location, please ATTACH a SEPARATE SHEET with this information.**

Primary Office: _____
Group Name and Clinic Name (if different)

Street Address: _____

City/State/ZIP: _____ County:_____

Office Phone Number: (_____)_____ ER/After Hours Number: (_____)_____

Fax Number: (_____)_____ Handicap Accessible ☐ Yes ☐ No

Tax ID Number (TIN): ___ ___ - ___ ___ ___ ___ ___ ___ ___ ___
As Listed on W-9

Corporate NPI: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Office Email:_____

Office Manager/Contact: _____ ☐ Clinic Hours ☐ Provider Hours

| Normal Office Hours: | **Mon.** | **Tues.** | **Wed.** | **Thurs.** | **Fri.** | **Sat.** | **Sun.** |
|---|---|---|---|---|---|---|---|
| Time Office Opens: | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| Time Office Closes: | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

Are you accepting new patients? ☐ Yes ☐ No

Are there any age limitations? ☐ Yes ☐ No Minimum Age:_____ Maximum Age: _____

Are there any gender restrictions? ☐ Males only ☐ Females only ☐ Both/no restrictions

Please describe any other patient limitations:

**BILLING INFORMATION (If different from mailing address)**

Billing Name: _____

Billing Address: _____

Office Manager/Contact: _____

Billing Phone Number: (_____)_____

Billing Tax ID Number (TIN): ___ ___ - ___ ___ ___ ___ ___ ___ ___

**GENERAL DENTISTRY EDUCATION**

| Institution | Grad Date | Degree |
|---|---|---|
| _____ | _____ | _____ |

**SPECIALTY EDUCATION**

| Institution | Specialty | Grad Date | Degree |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

For this specialty, I am:

☐ Educationally Qualified (attach copy of specialty certificate showing institution name, grad year and specialty)

☐ **American Board Certified** *(Attach Copy of certificate from the **American Board**)

* Date of Certification: _____ Expiration Date: _____

**PROFESSIONAL LIABILITY INSURANCE FOR EACH ENTITY IN WHICH YOU PRACTICE**
**(Complete this information or attach copy.)**

PL Carrier: _____ Policy Limits:_____ Effective Date:_____

PL Expiration Date:_____ Policy Number:_____

## DISCLOSURE QUESTIONS

Please **complete the malpractice or board action addendum** if any "yes" answers to questions 1 through 10.

1. ☐ Yes ☐ No **Have you ever** had your **professional license, registration or DEA** terminated, stipulated, restricted, limited, conditioned, subjected to corrective action, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?
2. ☐ Yes ☐ No **Have you ever** had your **membership, participation, clinical privileges or employment** denied, terminated, stipulated, restricted, refused, limited, suspended, revoked or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff or health-related agency or organization, or is there a review pending?
3. ☐ Yes ☐ No **Have you ever** voluntarily/involuntarily relinquished your **membership, participation, clinical privileges or request for privileges, employment, professional license or registration** as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?
4. ☐ Yes ☐ No **Have you ever** been reprimanded, censored or otherwise disciplined by, or have you 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**?
5. ☐ Yes ☐ No **Have you ever** had your certificate or participation in any private, federal (i.e., Medicare, Medicaid, etc.) or state health insurance program revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?
6. ☐ Yes ☐ No Are there any **charges pending or have you ever** been indicted, found guilty of a felony, misdemeanor (other than a minor traffic violation) or other offenses involving fraud, misrepresentation, dishonesty or deceit? Are you currently using illegal drugs?
7. ☐ Yes ☐ No **Have you ever** been found liable, guilty or responsible for sexual impropriety, misconduct or harassment?
8. ☐ Yes ☐ No **Have you ever** had any malpractice (professional liability) claims or lawsuits brought against you, including pending, dismissed or dropped claims/lawsuits, settlements or final judgments? (This includes status of any pending claims previously reported.)
9. ☐ Yes ☐ No **Have you ever** had your malpractice (professional liability) carrier refuse or cancel your coverage?
10. ☐ Yes ☐ No Do you have a condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing a significant health or safety risk to your patients?
11. ☐ Yes ☐ No Is your professional liability current with limits $1 million/$3 million?

## DISCLOSURE QUESTIONS & PROVIDER CONSENT

I hereby certify that to my knowledge 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 so while my application is being processed. I certify that my office protocols for infection control are in compliance with current CDC/OSHA guidelines. I agree to update changes in malpractice coverage, including changes in the insurance carrier or policy number, as they occur.

By completing this application to become a participating provider, I fully understand that any significant misstatement in, or omission from, my application to become a participating provider may constitute cause for denial of my application or the subsequent termination of my participating provider contract if my application is accepted. I understand and agree that this consent is irrevocable for any period during which I am a participating provider. Acceptance in any individual network is based on criteria established.

I understand that my application may require review of information related to me on file with other entities, including but not limited to, state licensing boards, specialty boards, professional societies, malpractice carriers and the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank administered by the U.S. Department of Health and Human Services.

I authorize release of information to complete this application.

I understand and agree that I have the responsibility of producing adequate information for proper evaluation of my continued professional competence, ethics and other qualifications, and for resolving any doubts about such qualifications. I further understand and agree that I have a continuing affirmative duty to immediately inform BlueCross of any future restrictions or revocation of my professional license, any disciplinary action, suspension or voluntary/involuntary limitation, denial of my clinical or other privileges or any other event which may adversely reflect upon my professional competence, ethics and other qualifications as a participating provider.

I understand that subject to proper confidentiality restrictions and authorizations, my dental records will be subject to inspection for quality assurance and utilization review purposes.

**Signature:** _____ **Date:** _____

**Name:** _____
(Please print or type)

# Malpractice or Board Action

Please complete addendum ONLY if you answered "Yes" to disclosure questions 1-9.
Attach separate sheet if necessary.

## Malpractice Claim(s)

Date of Occurrence: _____ Settlement Amount: _____

Name & Address of Insurance Carrier: _____

Current Status of Claim: _____ Date Claim Resolved: _____

Details of Allegations: _____

_____

_____

_____

_____

## Board Action(s)

Date of Occurrence: _____ Date of Satisfaction/Closure: _____ Amount of Fine Paid: _____

Details of Action (conditions, limitations, etc.) Attach Copy of Board Action/Corrective Action: _____

_____

_____

_____

_____

**EMPLOYMENT HISTORY**: Chronological listing must include MONTH and YEAR for each entry of employment history for the most recent five years. List all armed service, public health, education, business or professional activities, sabbatical, etc. LEAVE NO GAPS IN CHRONOLOGY.

| Date (Month & Year) | Facility and Address | Phone Number & TIN | Reason for Leaving |
|---|---|---|---|
| From: To: **present** _____ / _____ | Current Location | | |
| From: To: _____ / _____ | | | |
| From: To: _____ / _____ | | | |

**PRIMARY ADMITTING FACILITY** (List present hospital/surgical center privileges in chronological order beginning with the most recent.)

| | |
|---|---|
| Primary Admitting Facility: | _____ |
| Street Address: | _____ |
| City/State/ZIP: | _____ |

The selection process ensures that credentialing decisions are not based on an applicant's race, ethnicity/nationality, gender, age, sexual orientation or the types of patients or procedures in which the dentist specializes.

South Carolina

BlueChoice HealthPlan South Carolina

# Authorization for Clinic/Group to Bill for Services

Please complete this form to notify BlueCross BlueShield of South Carolina and BlueChoice HealthPlan that you have authorized a clinic/group/institution/location to bill for your services for Preferred Blue® (PPC), FEP and/or the State Health Plan and BlueChoice HealthPlan. Fax the completed form to 803-264-4795. If you have questions, email Provider.Cert@bcbssc.com.

This form does not qualify you to be a network provider.

BlueCross and BlueChoice HealthPlan reserve the right to accept or refuse authorization for a clinic/group/professional association/institution to bill for services.

**(Please type or print)**

Date of Request_____

I agree that _____ will bill for and receive charges or fees for my services
(EIN and Name of Clinic, Group or Professional Association)

effective _____.
(Date: MMDDYYYY)

Please list all locations for this clinic, group or professional association where this practitioner will be rendering services (if additional space needed, please attach list):

Physical Address/NPI:

_____ _____

_____ _____

_____
(Signature of Practitioner)

_____
(Practitioner's Name Printed)

_____
(Practitioner's SSN and NPI)

Do other clinics/groups/professional associations/institutions bill for your services? Yes ☐ No ☐
If yes, please list (Name and NPI):

_____ _____

_____ _____

_____
(Signature/Title of Clinic/Group/Professional Association/Institution Representative)

_____
(Representative's Contact Telephone Number)

Email Address (required for notification when we complete changes)

_____

Enter text directly into this form by placing your cursor on each blank. Click on boxes to select them, or tab to them and press your spacebar. You can also save this form to your computer. Use the "Clear Form" button on the right to delete all answers. Print the form and fax it to us to complete your application.