Delta Dental Legion Network Participation Application & Attestation

I. Treating Dentist Credentialing Information:

Treating Dentist Name: ______________ ______________ ______________________________ DDS DMD
(First) (M) (Last) (circle one)

Date of Birth: _______/_______/_______ Gender: Male ❑ Female ❑ SSN: ________-______-_________

☐ *Individual* National Provider Identifier (NPI-1): ___-___-___-___-___-___-___-___-___-___

Languages dentist speaks: ____

☐ General Dentist ☐ Specialist List specialty: ___________________ Board Certified or Eligible? ☐ No ☐ Yes

Dental License State: _______ License Number: _____________________ Exp. Date: ______/______/______

Dental School: ______________________ State or Country: ____________ Date Graduated: _____/_____/_____

Professional Liability Insurance (Malpractice) Carrier: ____

Policy Number: _________________ Expiration Date: _____/_____/____ Coverage Limits: __________________
(Copy of the Declarations page of current coverage is required)

DEA Certificate Number: ____________________ Exp. Date: _______/_______/_______

CHECK ONLY if the answer to any of the following questions is YES; please provide a detailed description of each checked question on a separate sheet and attach to this application.

☐ Have you ever had your State issued dental license revoked, suspended or canceled (from any state)?

☐ Have you had any adverse peer review actions, or been reported to the National Practitioner Data Bank or Healthcare Integrity & Protection Data Bank (NPDB/HIPDB)?

☐ Do you currently have a federal sanction (Federal Department of Health & Human Services, Office of Inspector General—DHHS-OIG)?

☐ Has your professional liability (malpractice) insurance ever been denied, canceled or not renewed?

☐ Have you been or are you currently a defendant in any malpractice action?

☐ Has your DEA license ever been limited, placed on probation, suspended, or revoked?

☐ Have you ever been convicted of a crime other than a minor traffic violation?

☐ Are you currently under investigation or indictment for an alleged criminal action(s)?

☐ Do you now have, or within the last five (5) years had, any physical condition, mental condition, substance or chemical dependency that does or has interfered with your ability to practice dentistry with or without accommodation?

I attest that the information provided on this application, including all attached documents, is complete and accurate. I agree to notify Delta Dental of California Federal Government Programs within fifteen (15) days of any changes to the information contained in this application. I further agree that any intentional submission of false or misleading information or the intentional omission of relevant information is grounds for immediate termination of the dentist's participation under the **Delta Dental Legion Participating Network Dentist Agreement.**

____ ____________________
Dentist Signature Date

II. Service Location Information (address to be listed on Dentist Directory)

Street Address (no PO Box): ____

City: ____ State: ______ Zip Code: _____________

Telephone: (_______) _________-________________ FAX: (______) __________-_________________

Dental office e-mail address: _________________________ Contact Name: ________________________

Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Standard (9-5)	☐	☐	☐	☐	☐	☐	☐
Early (before 8am)	☐	☐	☐	☐	☐	☐	☐
Late (after 6pm)	☐	☐	☐	☐	☐	☐	☐

Does the office meet all Federal and state OHSA requirements? ☐ Yes ☐ No

Does the office meet all ADA/CDC recommended infection control guidelines? ☐ Yes ☐ No

Languages spoken: ____

III. Payment Address Information (If different than the *above listed* Service Location address)

Address: ____

City: ____State: ________ ZIP Code: _________

Telephone: (_____) _______________________ FAX: (_____) ____________________________

IV. Billing Information

Billing Dental Group Name (DBA): ____

Tax ID (TIN): __________________________ *or* Employer ID (EIN): ___________________________

(Copy of the IRS confirmation letter is required; a copy can be requested by calling the IRS at 800-829-0115)

☐ *Organizational* National Provider Identifier (**NPI-2**): ___-___-___-___-___-___-___-___-___-___

INSTRUCTIONS:

- **PAGE ONE**: Complete for ***each*** location to be included as a Participating Service Location.
- **PAGE TWO**: Complete for ***each*** dentist applying for participation in the Delta Dental Legion Network.

ALL information must be complete or marked "n/a". The application must be signed and dated.
Incomplete applications will be denied.