Humana

Humana Dental Recredentialing Application

Please fill out each section completely and accurately to avoid delays with the recredentialing process.

Last name:	First name:		MI:
Federal tax ID:	Social Security Number:	Individual National Provider Identifier (NPI):	
Name as it appears on W-9:			
D.D.S./D.M.D.:	Date of birth:	Medicaid number:	
Office street address:			Suite:
City:	State:	ZIP:	
Mailing address, if different than above:			
Office phone number:	Office fax number:		
Office email address:	Website:		
State license number:			
Drug Enforcement Agency (DEA) Registration Number (If no number exists, please explain why):	Controlled Dangerous Substance (CDS) Registration Number – Texas only (If no number exists, please explain why):		
Professional liability carrier name:	Effective date:	Expiration date:	
Policy number:	Occurrence/claims limit:	Aggregate limit:	
Minimum age of patients accepted:			
Languages spoken (other than English):			
Specialists only			
Specialty:			
Board Certified ☐ Yes ☐ No	Name of certifying board:		

Please answer each question completely and accurately. If the answer to any of the questions below is "yes," please attach documentation explaining the response.

Disciplinary Actions		
1. Have any of the following been, or are in the process of, being investigated, suspended, reduced, limited, placed on probation, not renewed, voluntarily relinquished, revoked, canceled, denied or granted with stated limitations (either temporarily or permanently):		
Dental license in any state (within the past five years)?	☐ Yes	☐ No
DEA registration?	☐ Yes	☐ No
Board certification?	☐ Yes	☐ No
Clinical privileges?	☐ Yes	☐ No
Participation in any federal or state health program? For example: Medicare or Medicaid	☐ Yes	☐ No
Professional liability insurance?	☐ Yes	☐ No

2. Have you been convicted of a felony or misdemeanor other than minor traffic violations?	☐ Yes	☐ No
Insurance Information		
3. Has any professional liability suit, action or claim alleging malpractice been filed against you within the past five years?	☐ Yes	☐ No
4. Has any professional liability suit, action or claim been filed against you that is presently pending?	☐ Yes	☐ No
5. Have any judgments been made against you in professional liability cases or claims, or have you entered into any settlements within the past five years?	☐ Yes	☐ No
Health Status		
6. Is there any reason that you are not able to perform the essential functions of your position, with or without accommodation?	☐ Yes	☐ No
7. Are you currently engaged in the unlawful use of drugs?	☐ Yes	☐ No
Hospital Privileges and Other Affiliations		
8.Does the scope of your practice require clinical privileges? If yes, name the hospital. Hospital Name:_____ City:_____ State:____	☐ Yes	☐ No
9.Have your clinical privileges or medical staff membership at any hospital or health care institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or other disciplinary conditions (for reasons other than noncompletion of medical records when quality of care was not adversely affected), or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee, or governing board?	☐ Yes	☐ No

HUMANA DENTAL PLANS CONSENT AND RELEASE FORM FOR _____

(Please print applicant's name)

I hereby apply for participation in those Humana-offered or administered dental benefit plans and products covered under the separate participation agreement executed or to be executed by and between myself and identified Humana licensed dental health maintenance organization(s) and/or Humana insurance companies, included but not limited to HumanaDental Insurance Co., Humana Insurance Co., The Dental Concern Inc., The Dental Concern Ltd., CompBenefits Dental Inc., and their corporate affiliates who underwrite or administer group dental plans (hereafter severally and collectively as the "Plan") as requested in this application and I am willing to make myself available for interviews in regard to said application.

I acknowledge and agree that: (a) Privileges to participate as a provider with the Plan or Network is not a right; and (b) By applying for privileges with the Plan or Network I am agreeing to comply with the terms and conditions of the Participation Agreement ("Agreement"), whether signed by me or not, pursuant to which I am rendering services to Plan members either as a direct contractor, subcontractor, independent contractor, or covering dentist or dental provider.

Information given in or attached to this application is accurate and complete to the best of my knowledge. As a condition of making this application, any misrepresentation or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in the denial of my request for participation. In the event that

participation has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of participation with the Plan or Network.

For the purpose of obtaining and maintaining credentialing or privileges with the Plan or Network, I agree to hold harmless and from any and all liability the Plan or Network, its authorized representatives and any third parties, for any acts performed in good faith and without malice relating to any communications or disclosures of any kind involving me which are performed, of any otherwise privileged or confidential information. Such information may relate to, but not be limited to, information sharing on my professional qualifications, credentials, clinical competence and any other matter which might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of a health care facility on an ongoing basis.

It is understood by both parties hereto that any and all information obtained by the Plan or Network shall be confidential to the fullest extent permitted by law, regardless of whether my membership and privileges are approved or subsequently terminated, except as otherwise provided herein or in the separate participation agreement under which I will provide services to Plan or Network members.

The term "Plan, Network, and its authorized representatives" means the corporation(s) with which I have applied for participation, and any of the following individuals who may have any responsibility for obtaining or evaluating my credentials, or acting upon my application: the members of the Plan's or Network's board and their appointed representatives, the chief executive officer or his designees, other Plan or Network employees, consultants to the Plan, delegated credentialing entities, the Plan's or Network's attorney and his/her partners, associates or designees. The term "third parties" means all individuals, including appointees to the Plan's or Network's medical staff, hospitals, other physicians or health practitioners, nurses, government agencies, organizations, professional liability insurance carriers, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Plan, Network, or its authorized representatives or who have requested such information from the Plan, Network, and its authorized representatives.

As a condition of the Plan's or Network's acceptance of my application for participation privileges and in support of the Plan's or Network's commitment to continuous quality improvement and peer review, I hereby authorize the Plan, Network, and its authorized representatives to disclose and communicate with my employer, partners or affiliates, as applicable in relation to my provision of dental and related health care services to Plan or Network members, regarding actions or information relating to the Plan or Network credentialing, recredentialing and/or quality management programs.

As an applicant, I agree to produce adequate information for proper evaluation of my professional qualifications. I also agree to update the Plan or Network with current information regarding all responses and/or questions contained in this application and/or information obtained through the credentialing process as such information becomes available and any additional information as requested by the Plan, Network, or its authorized representatives. Failure to produce such information will prevent my application from being evaluated and acted upon, and may affect any existing privileges I have with the Plan or Network.

I further acknowledge and agree that communications and/or documents which are required in writing in order to comply with applicable laws and regulations shall be considered to be in compliance with any such laws and regulations, if transmitted, acknowledged and/or executed through the use of mail (email), electronic data interface (EDI), Internet or other electronic transmission.

I hereby acknowledge that this Consent and Release Form will be valid for a period of three (3) years from the date it is signed by me, and that a photocopy or fax will serve as an original.

I attest that I currently have professional liability insurance with coverage amounts equal to or exceeding those mandated by state regulations.

I certify that I have answered the questions truthfully and completely and I understand that, as a condition of making this application, any misrepresentations or misstatements in, or omission of any of these answers, whether intentional or not, shall constitute grounds for rejection of my request for participation with the Plan or Network. I certify that this application is complete and accurate to the full extent of my knowledge, and any affirmative answers have been explained in full on an attached sheet of paper.

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Applicant's Signature Date