EMI HEALTH DENTAL CREDENTIALING FORM

EMI Health • 852 East Arrowhead Lane • Murray, Utah 84107-5298 • 801-262-7975

PRACTICE

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER	GENDER

PRACTICE STATUS: ❑ INDIVIDUAL ❑ PARTNER ❑ GROUP ❑ OTHER: _____

PRACTICE OR GROUP NAME: _____

PRINCIPAL OFFICE LOCATION	SECONDARY OFFICE LOCATION
STREET	STREET
CITY / STATE / ZIP / COUNTY	CITY / STATE / ZIP / COUNTY
TELEPHONE / TAX ID NUMBER	TELEPHONE / TAX ID NUMBER
FAX / EMAIL ADDRESS	FAX / EMAIL ADDRESS
INDIVIDUAL NPI:	GROUP NPI:
	NPI USED FOR BILLING: ❑ YES ❑ NO

BILLING ADDRESS (if different than above)	CORRESPONDENCE ADDRESS (if different than above)
PAY TO NAME	CORRESPONDENCE NAME
ADDRESS	ADDRESS
CITY / STATE / ZIP / COUNTY	CITY / STATE / ZIP / COUNTY
TELEPHONE / CONTACT NAME	TELEPHONE / CONTACT NAME
DENTIST'S DATE OF BIRTH	OFFICE MANAGER'S NAME
PRIMARY STATE OF LICENSURE / LICENSE # (PLEASE ENCLOSE COPY)	SECONADARY STATE OF LICENSURE / LICENSE # (PLEASE ENCLOSE COPY)
DEA NUMBER (PLEASE ENCLOSE COPY)	LIST LANGUAGES IN WHICH YOU ARE FLUENT

SPECIALTY

❑ Endodontics ❑ Orthodontics ❑ Prosthodontics
❑ General Dentistry ❑ Pediatric Dentistry ❑Other: _____
❑ Oral & Maxofacial Surgery ❑ Periodontics

Please list any other services you provide: _____

For each specialty indicated, clarify that you are board certified or eligible to take boards and specify the name of the certifying board.

PRIMARY SPECIALTY Certified _____ Eligible _____ Certifying Board _____

SECONDARY SPECIALTY Certified _____ Eligible _____ Certifying Board _____

TRAINING

DO NOT FILL OUT DENTAL TRAINING SECTION WHEN RE-CREDENTIALING

Medical / Dental School	Location	Year Graduated
Internship	Location	Dates: From: To:
Residency	Location	Dates: From: To:
If Applicable: Foreign Dental Grad. Number:		

LIABILITY

Liability Carrier	Policy Number
Amount of Coverage per Occurrence	Aggregate

Malpractice Action:

Number of Pending Claims: _____ (if none, please write "none.")

Number of prior malpractice judgments or settlements within the last ten years: _____ (if none, please write "none.")

For each malpractice action, please attach an explanation to this application.

ENCLOSURES

Please submit the following with your application:

- ❑ 1. Signed contract (not applicable if re-credentialing)
- ❑ 2. Proof of malpractice coverage (the policy face sheet or certificate of insurance, with effective dates)
- ❑ 3. A copy of your current state license(s)
- ❑ 4. A copy of your DEA license
- ❑ 5. Completed W-9 tax form
- ❑ 6. Release of Information Authorization
- ❑ 7. Copy of Board Certificatation / Education Certificates (not applicable if re-credentialing)
- ❑ 8. Additional mailing, billing, or office addresses
- ❑ 9. Any explanations requested elswhere in this application
- ❑ 10. Any other information that you feel would be beneficial

PRACTICE REVIEW

Do you have other partners / associates in your practice? ❑ Yes ❑ No

Do you use dental assistants and / or hygienists? ❑ Yes ❑ No
(If yes, please attach names and license numbers for each.)

Have you been subject to any of the following:

Professional liability insurance cancellation in the past five years? ❑ Yes ❑ No

State licensing investigations or actions? ❑ Yes ❑ No

Conviction of a felony, fraud, moral, or ethical crime? ❑ Yes ❑ No

DEA licensing investigations or actions? ❑ Yes ❑ No

Chronic illness or physical defect that would impair your ability to practice your specialty? ❑ Yes ❑ No

Ownership in any facility or joint ownership of dental services or equipment with a facility to which you might refer patients? ❑ Yes ❑ No

Please attach an explanation of any questions answered "yes."

Are you routinely available for patient care at least four full days per week? ❑ Yes ❑ No

What are your office hours? _____

Do you offer emergency appointments? ❑ Yes ❑ No

What, if any, limitations do you have on the age range of your patients? _____

Approximately how many patients do you see per day, when in your office? _____

What, if any, limitations do you have on accepting new patients? _____

_____

Briefly describe your practice: _____

_____

CERTIFICATION

All information is complete and accurate to the best of my knowledge. I understand that this application does not entitle me to continued participation with EMI Health. I authorize EMI Health to consult with, and inspect all documents from individuals and organizations having information bearing on my qualifications. I agree that EMI Health, its representatives, and any individuals or entities providing information to EMI Health in good faith pursuant to this release shall not be liable for any act or omission related to the evaluation or verification of information in this application. I further agree to notify EMI Health of any change to the information requested by this application.

_____ _____

Signature of Responsible Party Date

EMI HEALTH™
Smart Benefits

PLEASE NOTE THAT THIS INFORMATION WILL BE TREATED AS CONFIDENTIAL