



# DenteMax<sup>®</sup> Enrollment Application Instructions

## Filling it out

- Use a blue or black ball point pen only. Do not use a pencil or felt-tip pen.
- Print legibly and in the boxes as shown
- Do not enter more than one character per box

**Example**  Yes

*All applicable fields are required. Incomplete or missing responses will cause delays and require follow-up. Partially completed forms may be faxed back to you at the number provided on the application.*

## The forms required are shown below in order of submission

**DenteMax contracts according to Tax ID Number (TIN). All doctors and locations associated with a participating TIN are considered to participate with DenteMax. Therefore, please complete and submit in this order:**

- 1. Location Application for each office location associated with a particular TIN
- 2. Provider Credentialing Application for each doctor \*
- 3. Provider Service Agreement for each doctor
- 4. Completed W-9

*\* Note: If you live in a state with a State Mandated Credentialing form, you must submit that as an alternative to the Credentialing Application. You must still submit the Location Application(s), Provider Service Agreement(s) and W-9(s).*

## Please verify when submitting

- All required fields are complete
- Authorized signature and date on all forms (last page)
- Current Professional Liability face sheet
- Explanation for any work history gaps greater than 6 months
- Explanation to any Professional Question answered with a "yes" (reason, dates, settlement amounts)

**Please do not staple or paperclip pages**  
Retain a copy of submitted documents for your files

## Specialty codes

Specialty Codes:

- GP:** General Dentist
- EN:** Endodontist
- OR:** Orthodontist
- OS:** Oral Surgeon
- PD:** Pediatric Dentist
- PE:** Periodontist
- PR:** Prosthodontist

*\* Note: You will need these codes for the Location Application*

Please note that missing/illegible information will delay processing. Completed forms should be sent to DenteMax Network Support at:  
E-Mail: [enrollment@dentemax.com](mailto:enrollment@dentemax.com)  
Fax: 888-586-0296  
Mail: 25925 Telegraph Rd, Ste 400  
Southfield, MI 48033

**Questions? Call us - we're here to help you! 1-800-752-1547**

*More than 5 locations or 8 dentists? Contact us to help you simplify the application process!*

**This sheet is for your reference only and does not need to be returned**



# Location Application

Please print clearly

Page 1 of 4

Example  Yes

Dentemax contracts according to Tax ID Number (TIN). All doctors and locations associated with a participating TIN are considered to participate with Dentemax.

## Dental office information

Tax ID used for claims

Type 2 NPI number

Legal name

Office / Directory name

Owner's name

Phone number

Fax number

E-mail address (optional)

Web site (optional)

Contact person

Contact person's title

## Physical address

Street address

Suite number

County

City

State

Zip code

Fax completed forms to 888-586-0296 or via e-mail to [enrollment@dentemax.com](mailto:enrollment@dentemax.com)

Source Code:

Resubmit Code:



# Location Application

Please print clearly

**Example**  Yes

**Mailing address** Is this the same as physical?  Yes  No *If no, complete the address below*

Street address

[Grid for Street address]

Suite number

[Grid for Suite number]

County

[Grid for County]

City

[Grid for City]

State

Zip code

[Grid for State and Zip code]

**Remittance address** Is this the same as physical?  Yes  No *If no, complete the address below*

Street address

[Grid for Street address]

Suite number

[Grid for Suite number]

County

[Grid for County]

City

[Grid for City]

State

Zip code

[Grid for State and Zip code]

## Office information

Office Hours

Start Time

A=AM  
P=PM

End Time

A=AM  
P=PM

Is your office multilingual?  Yes  No

If yes, please list languages below

Monday

[Grid for Monday Start Time]

[Grid for Monday AM/PM]

[Grid for Monday End Time]

[Grid for Monday AM/PM]

[Grid for Multilingual languages]

Tuesday

[Grid for Tuesday Start Time]

[Grid for Tuesday AM/PM]

[Grid for Tuesday End Time]

[Grid for Tuesday AM/PM]

[Grid for Multilingual languages]

Wednesday

[Grid for Wednesday Start Time]

[Grid for Wednesday AM/PM]

[Grid for Wednesday End Time]

[Grid for Wednesday AM/PM]

[Grid for Multilingual languages]

Thursday

[Grid for Thursday Start Time]

[Grid for Thursday AM/PM]

[Grid for Thursday End Time]

[Grid for Thursday AM/PM]

[Grid for Multilingual languages]

Friday

[Grid for Friday Start Time]

[Grid for Friday AM/PM]

[Grid for Friday End Time]

[Grid for Friday AM/PM]

[Grid for Multilingual languages]

Saturday

[Grid for Saturday Start Time]

[Grid for Saturday AM/PM]

[Grid for Saturday End Time]

[Grid for Saturday AM/PM]

[Grid for Multilingual languages]

Sunday

[Grid for Sunday Start Time]

[Grid for Sunday AM/PM]

[Grid for Sunday End Time]

[Grid for Sunday AM/PM]

How is your phone answered after hours?  Service  Machine

Describe your emergency coverage

[Grid for Emergency coverage description]

Source Code:

Resubmit Code:



# Location Application

Please print clearly

**Example**  Yes

## Office information continued

Is your office accessible to the physically disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does your office meet OSHA and CDC standards?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you prepared for a medical emergency/have kit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have portable oxygen with positive pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is someone in your office CPR certified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have an organized patient charting system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have functioning office equipment, including X-ray units, developing capability and lead irons?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Instrument sterilization type(s):	<input type="checkbox"/> Cold	<input type="checkbox"/> Autoclave	<input type="checkbox"/> Chemiclave <input type="checkbox"/> Dry Heat
Hand piece sterilization type(s):	<input type="checkbox"/> Surface Wipe	<input type="checkbox"/> Autoclave	<input type="checkbox"/> Bleeding Lines

## List the dentists practicing at this location *Please refer to Instruction Sheet for Specialty Codes*

1 1-First name

--

1-Last name

--

License number	Type 1 NPI number	Specialty Code

2 2-First name

--

2-Last name

--

License number	Type 1 NPI number	Specialty Code

3 3-First name

--

3-Last name

--

License number	Type 1 NPI number	Specialty Code

4 4-First name

--

4-Last name

--

License number	Type 1 NPI number	Specialty Code

Source Code:

Resubmit Code:







Credentials

License and Certifications continued:

Current CDS Certificate number  State  Expiration Date  Date format = MM-DD-YYYY

Current DEA Certificate number  State  Expiration Date  Date format = MM-DD-YYYY

Education

Dental school name

City  State  Zip code

Start Date  Date format = MM-YYYY Completion Date  Date format = MM-YYYY

Degree Awarded

Specialty Training

Institution name

City  State  Zip code

Start Date  Date format = MM-YYYY Completion Date  Date format = MM-YYYY

Did you successfully complete the program?  Yes  No

Board Certification

Are you Board Certified?  Yes  No

Certifying Board name

Hospital Affiliation

Do you have any hospital affiliations?  Yes  No if yes, please provide hospital name and location below

Hospital name

City  State  Zip code



Credentials continued

**Professional Liability Insurance**

Current carrier

[Grid for Current carrier]

Policy number

[Grid for Policy number]

Coverage limits (per occurrence)

Coverage limits (aggregate)

\$ [Grid for per occurrence coverage limits]

\$ [Grid for aggregate coverage limits]

Date format = MM-DD-YYYY

Date format = MM-DD-YYYY

Effective Date

[Grid for Effective Date]

Expiration Date

[Grid for Expiration Date]

**Important! Your current Professional Liability Face Sheet is REQUIRED with these forms.**

Work history - list all employment for the past 5 years

Most recent practice or employer name

[Grid for Most recent practice or employer name]

City

State

[Grid for City and State]

Date format = MM-YYYY

Date format = MM-YYYY

Start Date

[Grid for Start Date]

End Date

[Grid for End Date]

Second most recent practice or employer name below, if applicable

[Grid for Second most recent practice or employer name]

City

State

[Grid for City and State]

Date format = MM-YYYY

Date format = MM-YYYY

Start Date

[Grid for Start Date]

End Date

[Grid for End Date]

Third most recent practice or employer name below, if applicable

[Grid for Third most recent practice or employer name]

City

State

[Grid for City and State]

Date format = MM-YYYY

Date format = MM-YYYY

Start Date

[Grid for Start Date]

End Date

[Grid for End Date]

Source Code:

Resubmit Code:



Work History - list all employment in the past 5 years gaps greater than 6 months are required to be explained

Fourth most recent practice or employer name below, if applicable

[Grid for practice/employer name]

City [Grid] State [Grid]

Start Date [Date format = MM-YYYY] End Date [Date format = MM-YYYY]

Fifth most recent practice or employer name below, if applicable

[Grid for practice/employer name]

City [Grid] State [Grid]

Start Date [Date format = MM-YYYY] End Date [Date format = MM-YYYY]

Do you have any gaps in employment greater than 6 months?  Yes  No

Is this gap due to maternity leave?  Yes  No

If you have a gap in employment not due to maternity leave, you MUST provide a written explanation (preferably typed and on your office letterhead).

Languages Spoken

Are you multilingual?  Yes  No

If yes, please list languages below

[Grids for listing languages]

Acknowledgement

Dentemax contracts according to Tax ID Number (TIN). All doctors and locations associated with a participating TIN are considered to participate with Dentemax.

I acknowledge that all of the information contained in this application is accurate, complete and truthful to the best of my knowledge. I agree that I will provide written notification to Dentemax of any material change to the above. I understand that I have the right to review and correct any information used in the credentialing process.

The applicant has the right to: review information obtained by Dentemax in support of this credentialing application subject to applicable laws and excluding any peer review information; correct erroneous information; request the status of their application. This request must be made in writing to Dentemax.

Continue on page 5 for Professional Questions, Attestation and Signature

Source Code:

Resubmit Code:



# Credentialing Application

Page 5 of 5

Signature Required

Please print clearly

Example  Yes

If you live in a state with a mandated credentialing form, you must submit that as an alternative to this form

## Professional questions Please check Yes or No for each question

	Yes	No
1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been reprimanded, disciplined, counseled or been subject to similar action by any state licensing agency with respect to your license to practice?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your DEA or state controlled substances registration ever been restricted, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you currently under any investigation with respect to your DEA or state controlled substances registration?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been denied hospital privileges or have you ever voluntarily or involuntarily had any hospital privileges revoked, suspended (even if the suspension was stayed), reduced or nonrenewed?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have any disciplinary proceedings ever been instituted against you, or are any disciplinary actions now pending with respect to your hospital privileges or your license?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been denied, reprimanded, censured, excluded, suspended (even if the suspension was stayed), debarred or disqualified from participation in Medicare, Medicaid or any other governmental or quasi-governmental health-related program?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has your professional liability insurance coverage ever been denied, canceled, reduced, limited, not renewed or terminated by action of an insurance company?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any professional liability suits ever been entered against you, or are there any claims pending?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have any professional liability claims settlements, not involving litigation or arbitration, ever been paid by you or paid on your behalf?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been convicted of a felony or do you have any charges pending other than minor traffic offenses?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have a medical/psychiatric condition which in any way may impair or limit your ability to perform the essential job functions with or without reasonable accommodations as delineated by the practice of your specialty or privileges you will be requesting? (Please describe any accommodations required)	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you currently using illegal drugs or controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>
14. If you answered yes to the above question, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you to assure that you are not engaging in the illegal use of controlled dangerous substances?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of these questions, you must provide a written explanation (preferably typed on your letterhead). Please include all dates and settlement amounts.

## Attestation

In completing and signing this attestation, I:

- attest that the information in this application is complete, accurate, truthful and correct in all respects;
- understand that the submission of false and/or significantly misleading information or the withholding of relevant information is grounds for denial or termination of the contract;
- signify my willingness to appear for interviews in regard to my application;
- authorize DenteMax or its designated representatives to consult with others who have been associated with me and/or who have information bearing on my competence and qualifications;
- consent to DenteMax or its designated representative's inspection of all records and documents including, but not limited to, otherwise privileged and confidential information maintained by individuals, organizations and governmental entities which may be used to evaluate my professional qualifications and competence to carry out the practice privileges I request, my physical and mental health status, and my professional and ethical qualifications;
- release from liability and promise not to sue DenteMax and its designated representatives for their compilation and verification of my professional credentials;
- release from liability and promise not to sue any individuals, organizations and governmental entities that provide DenteMax or its designated representatives with information - including otherwise privileged and confidential information - concerning my competence professional ethics, character, physical and mental health, emotional stability, and other qualifications for panel appointment and practice privileges;
- agree to provide and update the information requested on my initial application and subsequent reapplications and privilege request forms;
- agree to maintain professional liability insurance and to notify DenteMax of any changes in coverage or status and of any changes, restrictions or limitations on my licensure or ability to practice my profession;
- acknowledge that DenteMax or its designated representatives may re-credential my application at any time without the need to secure my subsequent consent to do so and that I agree to and will cooperate in any re-credentialing process initiated by DenteMax under the same terms and conditions as outlined above.

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

Source Code:

Resubmit Code:



# Change Form

Please print clearly

**Example**  Yes

Are you changing name or specialty?  Yes  No *If yes, please complete the section below*

### Name currently on file

First name  Middle name

Last name

### New Name (you must provide a copy of your license showing this name)

First name  Middle name

Last name

### Specialty currently on file

General Dentist  Endodontist  Orthodontist  Oral Surgeon  Pediatric Dentist  Periodontist  Prosthodontist

### New Specialty

General Dentist  Endodontist  Orthodontist  Oral Surgeon  Pediatric Dentist  Periodontist  Prosthodontist

Are you updating your Tax ID number?  Yes  No *If yes, please complete the section below*  
**\* A new W-9 is also required \***

Tax ID currently on file  New Tax ID

Update all locations using this Tax ID?  
If no, which address should be changed?  Yes  No

Address 1 for this change

1-Suite number for this change

1-City for this change  State  Zip code for this change

Address 2 for this change

2-Suite number for this change  State  Zip code for this change

2-City for this change

Fax completed forms to 888-586-0296 or via e-mail to [enrollment@dentemax.com](mailto:enrollment@dentemax.com)

Source Code:

Resubmit Code:



# Change Form

Please print clearly

**Example**  Yes

## Addresses to change for your updated Tax Identification number *continued*

Address 3 for this change

3-Suite number for this change

3-City for this change

State

Zip code for this change

Address 4 for this change

4-Suite number for this change

4-City for this change

State

Zip code for this change

Are you changing your address?

 Yes No

*If yes, please complete the section below*

**Address 1 currently on file**

Current address

Current suite number

Current city

State

Current zip code

**New Address 1 below, and what type of address is this?**

 Physical Mailing Remittance

New address for this change

Suite number for this change

County

City for this change

State

Zip code for this change

Source Code:

Resubmit Code:



Address changes continued

Address 2 currently on file

Current address

Grid for current address

Current suite number

Grid for current suite number

Current city

Grid for current city

State

Current zip code

Grid for state and zip code

New Address 2 below, and what type of address is this?

Physical

Mailing

Remittance

New address for this change

Grid for new address

Suite number for this change

Grid for suite number

County

Grid for county

City for this change

Grid for city

State

Zip code for this change

Grid for state and zip code

Address 3 currently on file

Current address

Grid for current address

Current suite number

Grid for current suite number

Current city

Grid for current city

State

Current zip code

Grid for state and zip code

New Address 3 below, and what type of address is this?

Physical

Mailing

Remittance

New address for this change

Grid for new address

Suite number for this change

Grid for suite number

County

Grid for county

City for this change

Grid for city

State

Zip code for this change

Grid for state and zip code

