



800.752.1547

PLEASE CHECK THE APPROPRIATE BOX:

- | | |
|-------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> I am adding a provider | <input type="checkbox"/> I am changing my address |
| <input type="checkbox"/> I am adding a location | <input type="checkbox"/> I am changing my Tax ID |

Dental Office Information Sheet

DenteMax contracts according to Tax Identification Number (TIN). All doctors and locations associated with a participating TIN are considered to participate with DenteMax. Therefore, please complete a Dental Office Information Sheet for EACH location associated to the participating TIN. Please complete a Provider Service Agreement, a Dentist Application and a Professional Questions and Attestation for EACH doctor associated to the participating TIN.

Participating Dental Office Information

Office Name (Legal Name)		Tax ID Used for Claims	
Office Name (As it should appear in the Provider Directory if different)		Owner's Name	
Street Address		Suite Number	Email Address
City	County	State	Zip Code
Telephone Number () -		Fax Number () -	
		Contact Person at this Location	
		Contact Person's Title	
Please list all providers at this location. A Provider Service Agreement, Dentist Application and Professional Questions and Attestation must be completed for each provider.			

Miscellaneous Office Information

Office Hours (include evenings and weekends):

M:	T:	W:	Th:	F:	Sat:	Sun:
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Is your phone answered after hours? Yes No If Yes: Service Machine

Describe your after hours emergency coverage: _____

Is your office bilingual? Yes No If Yes, what language? _____

Is your office accessible to physically disabled? Yes No

Does your office meet OSHA and CDC standards and guidelines? Yes No

Are you prepared for a medical emergency? Yes No

Do you have a medical emergency kit? Yes No

Do you have portable oxygen with positive pressure? Yes No

Is someone in your office CPR certified? Yes No

Do you have properly functioning office equipment, including X-ray units, developing capability and lead aprons? Yes No

Do you have an organized patient charting and recall system? Yes No

Instrument sterilization type(s): Cold Autoclave Chemiclave Dry Heat None

Hand pieces sterilization type(s): Autoclave Bleeding Lines Surface Wipe None

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.

Signature _____

Date _____

Signed agreements, information sheets and any supporting documentation should be sent or faxed to:

DenteMax Provider Relations
25925 Telegraph Road, Suite 400
Southfield, MI 48033
Fax: 248.327.5299

DenteMax Provider Service Agreement

This agreement is between DenteMax®, and the Provider, _____, a duly licensed dentist, or a recognized entity to provide dental services in the state(s) of _____.

DenteMax is the owner and manager of a Preferred Provider Network which gives Participants access to its Providers through various individual and/or group dental plans.

The Provider desires to perform dental services for the Participants of the DenteMax program.

In consideration of the mutual promises contained herein, the parties agree as follows:

Definitions

Network shall mean Preferred Provider Network of dentists who, as Providers, have a contractual relationship with DenteMax to provide dental services under DenteMax established policies.

Provider shall be the owner of the tax identification number, or their duly authorized agent, and all other employees and/or independent practitioners of this entity who are licensed to practice dentistry in accordance with current state laws.

Payor shall mean an employer, administrator, insurance carrier, fund, individual or other entity who is responsible for the payment of the claim.

Participant shall mean persons, who through a dental plan with the Payor or by some other contractual relationship with DenteMax, are eligible to use the Network for dental care.

I. Responsibilities of Provider

1. Provider agrees to accept the current published DenteMax Fee Schedule, or the provider's usual fee if less, as full consideration for dental services provided to Participants. Provider agrees not to bill patient for the balance between the DenteMax fee and the provider's usual charge, if higher. The Participant may be responsible for plan limitations such as copayments, deductibles, and amounts exceeding the benefit maximums.
2. Provider agrees to treat DenteMax Participants as they would any other patient in their practice.
3. Provider is responsible for determining the eligibility and benefit coverage of the Participant.
4. Provider agrees to adhere to the guidelines established by the Payor for claims review and payment. Provider agrees to cooperate and furnish any material or information requested by the Payor or DenteMax required for claim payment and/or claim review.
5. Provider acknowledges that DenteMax is not liable for any payments due to the Provider including but not limited to the claim Payor or the Participant.
6. Provider agrees to accept and be responsible for his/her own acts or omissions in the professional practice of dentistry as well. Nothing in this agreement shall be interpreted or construed to place any such responsibility for professional acts or omissions on DenteMax.
7. Provider agrees to promptly notify DenteMax in writing of any change in status regarding licensure; insurance coverage or other material facts related to the information provided.

II. Responsibilities of DenteMax

1. DenteMax shall provide administrative and management duties in the development and maintenance of the Network.
2. DenteMax shall market its program to groups and individuals with the intent of obtaining Participants who may become patients of the Provider.
3. DenteMax is authorized to list information about the Provider in the DenteMax Provider directory, on the DenteMax website or other publications.
4. DenteMax shall have the right to amend this agreement by providing written notice. Failure of the Provider to reasonably object within thirty days of DenteMax sending the same shall constitute its acceptance.
5. DenteMax agrees to accept and be responsible for its own acts or omissions, as well as those of its employees, and nothing in this agreement shall be interpreted or construed to place any such responsibility onto the Provider.

III. General Provisions

1. This Agreement, the attached information sheets and dentist applications represent the entire agreement between the parties and supersedes all previous agreements, whether written or oral, between DenteMax and Provider.
2. Some states require certain contract provisions which are included by reference and in the attached Exhibit. If there is a conflict between provisions the state law shall take precedence.
3. This Agreement shall be effective when all providers have passed credentialing and are entered into the DenteMax Provider Database. The effective date of these additions shall be the sooner of the 15th day or last day of the month in which the change is made. This Agreement shall remain in effect until terminated by written notice of either party, with or without cause. Provider termination will be effective the final day of the month in which they are received.
4. DenteMax and Provider agree that each party is independent from the other and that the provisions of this agreement do not create an employer/employee, principal/agent, partnership, or joint venture relationship between the parties.
5. All notices, including but not limited to change of address and change of license status shall be submitted in writing and delivered either personally or by U.S. Mail postage prepaid to the address below or any new address supplied by the other party.
6. This Agreement may be assigned only by DenteMax.
7. This Agreement shall be governed by the laws of the State of Michigan.

Provider Signature

Date

Printed Name

Street Address

City

State

Zip

DenteMax
25925 Telegraph Road, Suite 400 • Southfield, MI 48033
800.752.1547 • Fax: 248.327.5299

Source: Website



800.752.1547

Dentist Application and Credentialing Information

Credentials verification services provided by: Aperture / Ingenix*

DenteMax Use Only
PLSID
TLID

PLEASE COMPLETE ALL ITEMS TO AVOID HAVING THE APPLICATION RETURNED

You may submit, and DenteMax will accept, any state mandated credentialing form as an alternative to this form.

Please provide the following information:

- Current Professional Liability Face Sheet
- Current State License Number: _____ State: _____
- Other Current State License Number: _____ State: _____
- CDS Certificate Number: _____ State: _____
- DEA Certificate Number: _____ State: _____

MICHIGAN ONLY																			
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Group BCBSM Pin #																			
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Individual BCBSM Pin #																			

Name: _____ DDS DMD MD
First Middle Last

Is there any other name(s) under which you have been known? _____ Male Female

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National Provider Identifier

--	--	--	--	--	--	--	--	--	--	--	--

Social Security Number

--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth Required (MM/DD/YYYY)

Specialty: General Practice Endodontist Oral Surgery Orthodontist Pediatric Dentist Periodontist Prosthodontist

Primary Office Name: _____

Street Address _____ City _____ State _____ Zip Code _____

Email Address (will be kept confidential) _____ Telephone Number _____ Fax Number _____

Hospital Affiliation: _____
Name City State Zip Code

Education: _____
Dental School Name City State Zip Code

Start Date: _____ / _____ Completion Date: _____ / _____ Degree Awarded: _____
Month Year Month Year

Specialty Training: _____
Institution Name City State Zip Code

Start Date: _____ / _____ Completion Date: _____ / _____ Did you successfully complete the program? Yes No
Month Year Month Year

Board Certified: Yes No Certifying Board: _____

Work History: List all employment for the past 5 years or provide a resume/curriculum vitae. To facilitate the credentialing process, please fill in the month and year. All gaps greater than 6 months are required to be explained on a separate sheet.

Practice/Employer _____ City _____ State _____ _____ / _____ to Present
Month Year

Practice/Employer _____ City _____ State _____ _____ / _____ to _____ / _____
Month Year Month Year

Practice/Employer _____ City _____ State _____ _____ / _____ to _____ / _____
Month Year Month Year

Professional Liability Insurance: _____
Current Insurance Carrier Policy #

Limits of Coverage: \$ _____ / \$ _____ Effective Date: _____ / _____ Expiration Date: _____ / _____
Month Year Month Year

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. All Rights Reserved. No part of this document may be reproduced without the express written permission of DenteMax. *Aperture / Ingenix is a credentials verification organization under contract to DenteMax.

Professional Information

Please check YES or NO for each question.

	YES	NO	N/A
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"/>	<input type="checkbox"/>

If you answered yes to any of these questions, please provide an explanation on a separate sheet. An NPDB self queried report(s) is acceptable as supporting documentation if you desire to provide it. Otherwise, documentation of some other form is required to be submitted with your Professional Questions and Attestation.

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 representatives' 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 anytime without the need to secure my subsequent consent to do so and that I agree to and will co-operate in any re-credentialing process initiated by DenteMax under the same terms and conditions as outlined above.

Applicant Signature

Print Name

Date