PROVIDER APPLICATION

Please complete **ALL** blanks. If not applicable, please put "N/A." Any changes must be lined through, initialed and dated. DO NOT USE WHITEOUT. Incomplete applications will delay processing.

PLAN ELECTION SECTION:

The dental plan options are listed below. Please choose the plan(s) in which you are interested in participating (Your application may be delayed if all boxes that apply are not checked off):

FCL DENTAL/PDP {ANY STATE LICENSE TO DO BUSINESS IN)

☐ PDP (Provider Dental Plans)

FCL DENTAL/DENTAL SOULTIONS PLUS {TENNESSEE/MISSISSIPPI ONLY}

☐ Dental Solutions Plus Discount Plan

MEDICARE/MEDICAID PLANS {ANY STATE LICENSE TO DO BUSINESS IN)

☐ Medicaid Plans
☐ Medicare Plans

FCL DENTAL/ORAQUEST {TEXAS ONLY}

☐ OraQuest Dental Plans – DHMO

FCL DENTAL/DENTAL SOURCE {KANSAS-MISSOURI ONLY}

☐ Dental Source-DHMO-Plan E
☐ Dental Source-DHMO-Plan H
☐ Free Access Plan (FAP)
☐ Safeguard

DINA/GUARANTY ASSURANCE {LOUISIANAONLY}

☐ DINA PPO
☐ DINA Pre-Paid
☐ Peoples Health Network

Fill out the application materials to join our networks and return them to us. Be sure to include copies of appropriate licenses and certifications as indicated on the application. Additional documentation may be sent to and/or requested from you.

Your application materials will be reviewed and, if you are accepted as a participating dentist, you will receive notification from us welcoming you into our network.

We look forward to your participation. If you have any questions about which plans are in your state or need additional forms, please call the Dentist Provider line at **1-877-493-6282** from 8 a.m. – 5 p.m. ET, Monday – Friday.

ITEMS REQUIRED FOR PROVIDER APPLICATION TO BE CONSIDERED:

- ☐ Signed Dental Provider Agreement(s)
- ☐ Completed Provider Application with Work History (CV or Resume are Acceptable)
- ☐ W-9 Form
- ☐ Legible Copy of Dental License (for all states in which you are licensed)
- ☐ Legible Copy of Professional Liability Insurance Declaration Page (with Expiration Date)
- ☐ Legible Copy of DEA Controlled Substance Certificate
- ☐ Legible Copy of State Controlled Substance Certificate (If applicable in your state)
  If you do not have a narcotics license please include a signed statement indicating the name of the credentialed provider that will be available to write any necessary narcotic prescriptions.
- ☐ Copy of Radiation Certificate or Inspection Letter

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ADDITIONAL OFFICE INFORMATION (IF APPLICABLE)

Treating Address City State Zip Code + 4 County

Office Phone Office Fax Email Credentialing Contact Title Phone

Office Name Organizational NPI

Billing/Mailing Address (if different from Treating Location) City State Zip Code Phone

☐ SSN ☐ EIN/TIN

Corporation Name/Billing Entity (Exactly as Listed with IRS) SSN/TIN (For Billing Purposes)

Correspondence Address (Credentialing/Re-credentialing Documents) City State Zip Code Phone

Office Hours Mon ______________ Tues ____________ Wed ____________ Thurs ____________ Fri ____________ Sat ____________ Sun ____________

Are you accepting new patients? ☐ Yes ☐ No Is your office open after normal business hours (Monday through Friday, 9 am – 5 pm)? ☐ Yes ☐ No

After Hours/Emergency Coverage: ☐ Answering Machine ☐ Answering Service ☐ Pager ☐ Coverage by another office ☐ None

Emergency Telephone ______________________________ Accommodations are adequate for disabled patients (Meets ADA Standards)? ☐ Yes ☐ No

Patient Age Limits Minimum Age _____________ Maximum Age _____________ Claims Submitted Electronically ☐ Yes ☐ No

Languages Spoken (Staff) ☐ English ☐ Spanish ☐ Other _______________ Languages Spoken (Dentist) ☐ English ☐ Spanish ☐ Other_______________

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Office Phone Office Fax Email Credentialing Contact Title Phone

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For each location added, please attach Radiation Certificate/X-Ray Inspection Letter (if applicable) and Corresponding W-9