



# DENTAL RE-CREDENTIALS VERIFICATION

**INSTRUCTIONS:** This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

PRACTITIONER/PRACTICE INFORMATION					
NAME (LAST)		(FIRST)		(MIDDLE)	
SOCIAL SECURITY NO. (SSN)		PERSONAL NPI NUMBER		PRACTICE NPI NUMBER	
				<input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> _____	
				GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE DATE OF BIRTH	
TAXPAYER IDENTIFICATION NUMBER USED: <input type="checkbox"/> SSN or <input type="checkbox"/> EIN (EMPLOYER IDENTIFICATION NUMBER)				DOES YOUR OFFICE COMPLY WITH OSHA/CDC STANDARDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
List # _____					
PRACTICE NAME					
PRIMARY OFFICE STREET ADDRESS		CITY		STATE ZIP	
TELEPHONE NUMBER		OFFICE FAX NUMBER		E-MAIL	
DENTAL LICENSURE			BOARD CERTIFICATION		
STATE OF _____		LICENSE NUMBER / EXP. DATE		SPECIALTY DATE CERTIFIED/RECERTIFIED	
OTHER CERTIFICATIONS (ATTACH CERTIFICATE IF APPLICABLE) Examples Include: ACLS, BLS, ATLS, PALS, NRP, E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.					
TYPE(S):		NUMBER(S):		EXP. DATE(S):	
CURRENT HOSPITAL & OTHER INSTITUTIONAL AFFILIATIONS					
FACILITY NAME:		ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/>		STAFF PRIVILEGES YES <input type="checkbox"/> NO <input type="checkbox"/>	
PROFESSIONAL LIABILITY					
NAME OF CARRIER			POLICY NUMBER		
Delta Dental requires a \$500,000 minimum per claim and a \$1 million minimum aggregate amount LIST YOUR LIMIT PER CLAIM / AGGREGATE AMT:				EFFECTIVE DATE EXPIRATION DATE	
PROFESSIONAL STATUS					
If you answer "yes" to any of the following questions, please give full details on a separate sheet of paper.					
				YES	NO
1. In the past three years, have you had any malpractice claims or suits filed against you? If yes, did any of these result in a settlement? If yes, please explain: _____				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
2. To your knowledge, in the past three years, have you been the subject of an investigation or disciplinary action by any licensing board or hospital as of the date of this application? If yes, please explain: _____				<input type="checkbox"/>	<input type="checkbox"/>
3. In the past three years, have you had any professional liability insurance denied, canceled or not renewed? If yes, please explain: _____				<input type="checkbox"/>	<input type="checkbox"/>
4. In the past three years, have you had any certificate/license by any Board or agency revoked, suspended, voluntarily surrendered, limited or otherwise sanctioned? If yes, please explain: _____				<input type="checkbox"/>	<input type="checkbox"/>
5. In the past three years, have you been denied a DEA registration number or been issued a restricted DEA registration? If yes, please explain: _____				<input type="checkbox"/>	<input type="checkbox"/>

I acknowledge that information relating to this application may be investigated and verified by Delta Dental and/or its Representatives and agree that all information contained herein is true and complete, including my NPI which is a component of the credentialing/recertification process.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

DELTA DENTAL REVIEW: \_\_\_\_\_

REVIEW DATE: \_\_\_\_\_

Insurance products provided by Oregon Dental Service, doing business as Delta Dental of Alaska.