DENTAL PROVIDER APPLICATION (without CAQH)

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

APPLICATION FORM
DENTAL PROVIDER

BlueCross BlueShield Arizona

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Thank you for your interest in becoming a contracted dental provider. In order to be considered for a contract with Blue Cross® Blue Shield® of Arizona (BCBSAZ) you must successfully complete the credentialing process.

All providers are encouraged to utilize CAQH (the Council for Affordable Quality Healthcare) for credentialing and subsequent renewals. Use of CAQH is free for providers and registration can be completed online at ProView.CAQH.org.

Please complete this application as indicated (option 1 with CAQH or option 2 without CAQH):

1. Application with CAQH – Please indicate your CAQH Provider ID Number: _____

   Complete **pages 1-3 only** of this application form in full, and then save, attach, and email the form to **ProviderApps@dominionnational.com** or fax to **BlueDental℠ Administrator** at **1-888-345-2040.**

2. Application without CAQH – Please complete **all 10 pages** of this application form in full (print, read, and sign page 9). Then save, attach, and email all pages of the form, along with supporting documentation, to **ProviderApps@dominionnational.com** or fax to **BlueDental℠ Administrator** at **1-888-345-2040.**

   Supporting documentation includes:

   - A **curriculum vitae** (CV) or work history form, **including month and year**, for the last 5 years
   - A copy of your **current malpractice insurance certificate**

You have the right to review information submitted by or from other sources in support of your credentialing application, and to correct erroneous information.

NOTE: Any missing items or incomplete required fields will significantly delay the processing of your application.

The completion of this form does not guarantee network participation. If you have questions regarding the contracting process, please contact Provider Network Relations at 1-888-271-7806.

I am requesting: ☐ **Dental** ☐ **FEP Dental (except Oral Surgeons)** ☐ **Medical (Sleep Apnea, TMJ and Oral Surgery)**

PROVIDER NAME and DEGREE: *(Required)*	Last	First	MI	Degree (MD, DO, etc.)	
	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy) / /	Social Security	Birth Place	
OTHER NAME(S) USED:	Last	First	MI		
INDIVIDUAL NPI: *(Required)*	Individual NPI	Effective date (mm/dd/yyyy) / /			
LICENSE: *(Required)*	License Number:	Date you were first licensed to practice in AZ: (mm/dd/yyyy) / /			
OTHER ID NUMBERS: *(Required)*	DEA #: _____ Expiration Date: _____/_____/_____				
	Medicare B #: _____ Effective Date: _____/_____/_____				
	UPIN ID #: _____ Effective Date: _____/_____/_____				

ARE YOU ACCEPTING NEW PATIENTS? ☐ Yes ☐ No *(Required)*		
GROUP NAME: (Claim payments may be made to the Group Name / NPI Number) *(Required)*	Group Practice Name (DBA)	
	Group/Organization NPI	Effective date (mm/dd/yyyy) / /
TAX ID and START DATE: *(Required)*	Tax ID	Start date (mm/dd/yyyy) (date when this provider starting billing with tax) / /

SPECIALTY / TAXONOMY: Please note, what you indicate as your practicing specialty(s) will be how you are listed in the BCBSAZ Provider Directories. *(Required)*	Check applicable box: ☐ Hospital Based ☐ Office Based			
	Primary Practicing Specialty			
	Other Practicing Specialty(s), as applicable			
	Individual Taxonomy			
SPECIALTY BOARD CERTIFIED? ☐ Yes ☐ No If **YES**, please attach a copy of each Board Certificate	Name of Specialty Board			Certificate#
	Certified (mm/dd/yyyy) / /	Recertified (mm/dd/yyyy) / /	Expires (mm/dd/yyyy) / /	
SPECIALTY BOARD CERTIFIED? ☐ Yes ☐ No If **YES**, please attach a copy of each Board Certificate	Name of Specialty Board			Certificate#
	Certified (mm/dd/yyyy) / /	Recertified (mm/dd/yyyy) / /	Expires (mm/dd/yyyy) / /	
INDIAN HEALTH CARE PROVIDER: *(Required)*	Are you an Indian Health Care Provider? ☐ Yes ☐ No			
OTHER LANGUAGES SPOKEN BY PHYSICIAN: (Not staff)	1.	2.	3.	

HOSPITAL /FREE STANDING SURGERY FACILITIES PRIVILEGES: *(Required)* If space for additional facilities is needed, please attach a separate sheet.

Facility Name:	☐ Active ☐ Courtesy ☐ Delivery ☐ Provisional
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ASC PRIVILEGES (Facility Names):	

OFFICE CONTACT: *(Required)*	Name							
	Office Contact Email Address		Phone		Fax			
BUSINESS WEBSITE: *(Required)*	Website							
BUSINESS EMAIL: (for contracts and correspondence) *(Required)*	Provider Business Email (contracts and correspondence must be sent to the provider, not to a billing company or a consultant)							
PRIMARY ADDRESS: Primary address must be a physical location in Arizona, where services are performed. *(Required)*	Street Address						Suite	
	City				State		Zip	
	Phone (Patient Scheduling Number)		Fax		Authorization/Referral Fax			
	Office Hours	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
	Start Time							
	End Time							

BILLING ADDRESS: (Contracted provider payments will be sent to this address) *(Required)*	Street Address				Suite
	City			State	Zip
	Phone		Fax		
MAILING ADDRESS: (Correspondence will be sent to this address) *(Required)*	Street Address				Suite
	City			State	Zip
	Phone		Fax		
CREDENTIALING CORRESPONDENCE: (If different than Mailing Address)	Street Address				Suite
	City			State	Zip
	Phone		Fax		
MEDICAL RECORDS: (If different than Primary Address)	Street Address				Suite
	City			State	Zip
	Medical Records Email		Phone		Fax
ADDITIONAL OFFICE(S) for this Tax ID #: Add only locations where the provider is actively practicing on a regular basis. Do not include locations where the provider works occasionally or covers for other providers.	Please note: Claim processing for professional providers is based on NPI and tax ID number(s), not office locations.				
	Street Address				Suite
	City			State	Zip
	Phone		Fax		Authorization/Referral Fax

Office Hours	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Start Time							
End Time							

Additional Information / Comments:

Authorized Electronic Provider Signature: I am _____, and I verify that the information provided on the first 3 pages of this form is current and accurate. I agree that by entering my name in the electronic signature field below, I am verifying the information as provided.

/s/_____ _____/_____/_____

Authorized Electronic Provider Signature Date

Save, attach, and email form to: ProviderApps@dominionnational.com or fax to BlueDental Administrator at 1-888-345-2040. Call 1-888-271-7806 with questions.

INITIAL CREDENTIALING INFORMATION

The following items are required to begin the initial credentialing process. If any of the items are not completed/provided with the application, it may cause a delay in the processing of your file and the receipt of a contract.

- ☐ Completed credentialing application, including all questions answered and a signature on the attestation/release
- ☐ If you answered yes to any of the questions, a **typewritten**, detailed explanation, in your own words (or your attorney's), of the case/issue is required **(failure to provide this information will delay the processing of your file**)
- ☐ Current Arizona practice license **(if you do not have your Arizona practice license, we cannot process your file**)
- ☐ Current DEA certificate, if applicable (**if you are required to have a DEA but have not yet obtained one, we cannot process your file**)
- ☐ Current certificate of malpractice insurance for practice in Arizona, with minimum limits of $1,000,000 per occurrence/$3,000,000 aggregate (**if expired, cannot complete file until we receive a current copy**) or completely fill in the insurance portion of the application
- ☐ Completion of residency (MDs and DOs) is required if graduated from medical school after 1991 (if currently in a residency program, we will accept an application within 60 days of completion of the program; **however, we cannot complete the file until we are able to verify from the residency program that you successfully completed the program**)
- ☐ Fellowships (if currently in a fellowship program, we will accept an application, **however, the BCBSAZ directory will reflect your specialty based upon your residency, not the fellowship**. After completion of the fellowship, you may request a specialty change.)
- ☐ Complete work history, including month and year, for the last 5 years, **with an explanation of any gaps in work history. (Failure to provide the explanation will delay the processing of your file)**

The following items will automatically disqualify you from receiving a contract:

- License restriction/probation for anything other than alcohol/substance abuse (may apply when the restriction/probation has been lifted)
- Any complaints regarding sexual misconduct (may apply if the complaint is eventually found to be unsubstantiated)
- Substantiated proof of intentional falsification (including or omitting) of medical records, prescriptions or other medical documentation
- Felony plea or conviction of any kind within the previous 6 years (provider may apply and be considered if more than 6 years have elapsed since the date of conviction or plea, and if the provider is not incarcerated or subject to a federal debarment order at the time of reapplication)

This is not a complete listing of BCBSAZ credentialing requirements. Providing the above information does not guarantee that a provider will meet BCBSAZ's credentialing requirements.

Please Note: A contract cannot be extended to you until you have successfully completed the credentialing process.

If you do not have a CAQH Membership (see page 1), fill out this application **completely**, attach additional sheets if the space to answer is not sufficient, and include all requested supporting documents. Failure to do so will significantly delay the application and credentialing process.

I. PROVIDER QUESTIONNAIRE

1. ☐ Yes ☐ No	Do you have any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients?
	If yes, please explain, and indicate whether you have disclosed this to the regulatory board for your profession, and attach written documentation verifying the report.
2. ☐ Yes ☐ No	Have you ever been convicted of a criminal offense involving the possession, use, purchase, distribution, or sale of drugs?
	If yes, please explain.
3. ☐ Yes ☐ No	Has your license to practice medicine in any jurisdiction (including other states) ever been denied, restricted, limited, suspended, or revoked?
	If yes, please explain.
4. ☐ Yes ☐ No	Have you ever been reprimanded by a licensing agency, including a Stipulation and Order (voluntary or involuntary), Letter of Reprimand, Censure, or any other such activity/action?
	If yes, please explain.
5. ☐ Yes ☐ No	Have your privileges or membership at any hospital, institution, or managed care organization ever been denied, suspended, reduced, or not renewed, or have disciplinary proceedings ever been instituted against you?
	If yes, please explain.
6. ☐ Yes ☐ No	Have you ever withdrawn your application for appointment, reappointment of privileges, or resigned from the staff of a healthcare facility or managed care organization before a decision was made by the healthcare organization's governing board?
	If yes, please explain.
7. ☐ Yes ☐ No	Have you been subject to sanctions by a professional standards review organization (PSRO) or by a utilization and quality control peer review organization (PRO)?
	If yes, please explain.
8. ☐ Yes ☐ No	Has your narcotic license ever been suspended, revoked, restricted in any manner, voluntarily/involuntarily relinquished, or is it currently being challenged?
	If yes, please explain.
9. ☐ Yes ☐ No	To the best of your knowledge, have you ever been or are you under investigation by a regulatory agency (e.g., state licensing board, State Department of Health, Medicare, Medicaid, or IRS)?
	If yes, please explain.

10. ☐ Yes ☐ No	Have you ever been sanctioned, expelled, or suspended from receiving payment or voluntarily resigned under threat of same by Medicare, Medicaid, or other Federal programs, HMO, PPO, or any other insurance-type programs or any other authority?
	If yes, please explain.
11. ☐ Yes ☐ No	Have you ever been denied professional liability insurance or has your professional liability insurance ever been terminated or not renewed?
	If yes, please explain.
12. ☐ Yes ☐ No	Have you ever had a malpractice claim made against you, been a defendant in a malpractice suit, had any settlements made on your behalf, or had claims paid as a result of arbitration?
	If yes, please explain.
13. ☐ Yes ☐ No	Have you ever been convicted of a felony or misdemeanor charge, including DUIs, or are there any charges pending? Exclude only non-DUI related misdemeanor traffic violations?
	If yes, please explain.
14. ☐ Yes ☐ No	Have you been the subject of an administrative, civil, or criminal complaint or investigation regarding sexual conduct?
	If yes, please explain.

Provider Applicant Name:	

II. CURRICULUM VITAE AND/OR WORK HISTORY

Attach your current curriculum vitae and/or work history to this application, including month and year for the last 5 years.

Please explain any gaps in your work history.

A Work History Form is attached for your convenience.

III. OTHER STATE LICENSES

Other State Practice Licenses: (List any healthcare licenses ever held and an explanation of any licenses that are not current)	State	License Number	Explanation if not current
	State	License Number	Explanation if not current
	State	License Number	Explanation if not current

IV. EDUCATION AND TRAINING

Schools	Medical, Dental, etc. College	Degree	Date of Graduation (mm/dd/yyyy)
			/ /
	Other professional training	Degree	Date of Graduation (mm/dd/yyyy)
			/ /

Internships/ Residencies (List every internship or residency begun or completed)	Institution (mm/yyyy)	Address	Type of internship/residency	Dates (mm/dd/yyyy)
	/			/ /
	Institution (mm/yyyy)	Address	Type of internship/residency	Dates (mm/dd/yyyy)
	/			/ /
	Institution (mm/yyyy)	Address	Type of internship/residency	Dates (mm/dd/yyyy)
	/			/ /
	Institution (mm/yyyy)	Address	Type of internship/residency	Dates (mm/dd/yyyy)
	/			/ /

Fellowships	Institution (mm/yyyy)	Address	Type of Fellowship	Dates (mm/dd/yyyy)
	/			/ /
	Institution (mm/yyyy)	Address	Type of Fellowship	Dates (mm/dd/yyyy)
	/			/ /

V. HOSPITAL AFFILIATION-PRIMARY HOSPITAL ONLY

Primary Hospital		
Department	**Category**	**Dates of Staff Membership (mm/dd/yyyy to mm/dd/yyyy)**
		/ / to / /

VI. PROFESSIONAL LIABILITY INSURANCE

Please complete this portion in full for your current malpractice insurance that is in effect **for your Arizona practice (not a residency/fellowship)**, YOU MUST also provide a copy of a current malpractice insurance certificate with this application.

Please note, if your certificate of insurance is not provided, it will significantly delay the processing of your application.

Name of Current Carrier			
Effective Date (mm/dd/yyyy)	**Expiration Date (mm/dd/yyyy)**	**Amount of Coverage**	**Policy Number**
/ /	/ /		

VII. COVERING PROVIDERS/COVERAGE PLAN

The BCBSAZ Credentialing Guidelines require that you supply the names of covering providers. In lieu of covering providers, a detailed explanation of your coverage plan would be acceptable. This requirement does not apply to the following provider types: Dentists, Chiropractors, Pathologists, Radiologists, Hospitalists, Optometrists, ER Physicians, Registered Dieticians, Audiologists, Lactation Consultants, Physical Therapists, Occupational Therapists, Speech Therapists, and Urgent Care Providers.

PLEASE LIST THE PROVIDERS WHO WILL COVER IN YOUR ABSENCE:	Name	Office Phone
	Name	Office Phone

24 Hour Coverage? ☐ Yes ☐ No

If yes: ☐ Answering Service ☐ Voice Mail with Instructions to call Answering Service ☐ Voice Mail with other instructions

Other:

VIII. RELEASE AND ATTESTATION

All submitted information is considered confidential and shall not be disclosed to third parties other than BCBSAZ and its employees (other than to the physician or practitioner involved) except with respect to the professional peer review activity or as required by federal or state law.

I, _____ *(Print Full Name)*, attest that all the information submitted in this application is correct to my best knowledge and belief. I certify that all questions have been answered fully and completely. I understand any misstatement may constitute cause for denial of my application or termination of my participation agreement. I understand that omission of any information on this application may result in the automatic denial of my application for participation or the termination of my existing contract, whichever is applicable. I understand and agree, that I, as the applicant, have the burden of producing adequate information for proper evaluation of my professional competence, entire malpractice experience, disciplinary action by licensing boards and/or healthcare facilities, character, ethics, and other qualifications and for resolving any questions about such qualifications.

I hereby grant to BCBSAZ and its authorized agents the right to obtain and confirm documentation and information, including confidential privileged information pertaining to my credentialing application.

For purposes of evaluating my professional competence, character and ethical conduct, I further authorize BCBSAZ, their professional staffs and legal representatives, to:

1) Contact and consult with any person and/or entity, including but not limited to, administrators and members of the professional staff of any healthcare facility, institution, professional society, or practice with which I have been associated; and
2) Inspect all records and documents, including health records at other treatment facilities, from individuals and organizations that may be material for the evaluation of my professional qualification, including information relating to any disciplinary action, suspension, or curtailment of practice privilege

I hereby release from liability:

1) BCBSAZ and all of its representatives, peer review committee members, officers, directors, and employees for their acts in good faith and without malice, in connection with evaluating my application and my credentials for qualification; and for disclosing collected information as required for delegated credentialing; and
2) BCBSAZ peer review committee members, officers, directors, and employees for claims, damages, losses, causes of action, judgments, settlements incurred by them which are caused by or related to intentional misrepresentation or inaccuracy or false statements knowingly made by me; and
3) **All individuals, organizations or entities, including but not limited to healthcare facilities in connection with providing and transmitting, if acting in good faith and without malice, related to the subject matter addressed by this application. I consent to the release of such information whether in the form of transcripts, records, tapes, letters, photocopies or duplications of any of the foregoing or verbal statements by hospital or clinic administrators, representatives of clinical departments of hospitals in which I have served on staff, healthcare clinics, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), insurance carriers/agents, governmental agencies including the NPDB-HIPDB, or other individuals or organizations who or which possess information about me. Such information may be released only to BCBSAZ for the purpose of credentials verification.**

I further consent and agree:

1) This authorization is effective for a period of two years or until the next recredentialing date, whichever occurs first.
2) To notify BCBSAZ immediately of any material changes concerning my professional status; and
3) A facsimile or photocopy of my signature will serve the same as the original.

I understand and accept that BCBSAZ has the right, at BCBSAZ's sole discretion, to deny my application to participate in BCBSAZ, without cause or explanation, or terminate my existing contract in accordance with its terms, whichever is applicable. If I do not have an existing contract with BCBSAZ, I understand that I do not have any appeal rights and will not be eligible to participate as a BCBSAZ contracted provider unless or until I have received a Letter-of-Welcome as a contracted provider.

This attestation page must be signed by the actual provider who is applying for participation. This signature cannot be a stamp. Please note: if you have provided a CAQH number on page 1, the CAQH signature will be used.

_____ _____ / / _____

Signature of Provider Applicant *(Required)* Date *(Required)*

IX. WORK/CLINICAL HISTORY (Optional if CV is supplied)

Please complete the following form showing work/clinical history **for the last 5 years**. You must include **month** and **year**, name(s) of school/training facility, practice/group and address of each.

If you send a Curriculum Vitae it must include month and year for all dates.

Date From (mm/yyyy)	Date To (mm/yyyy)	Name of School, Practice/Group	Address of School/Facility, Practice/Group
/	/		
Date From (mm/yyyy)	Date To (mm/yyyy)	Name of School, Practice/Group	Address of School/Facility, Practice/Group
/	/		
Date From (mm/yyyy)	Date To (mm/yyyy)	Name of School, Practice/Group	Address of School/Facility, Practice/Group
/	/		
Date From (mm/yyyy)	Date To (mm/yyyy)	Name of School, Practice/Group	Address of School/Facility, Practice/Group
/	/		
Date From (mm/yyyy)	Date To (mm/yyyy)	Name of School, Practice/Group	Address of School/Facility, Practice/Group
/	/		
Date From (mm/yyyy)	Date To (mm/yyyy)	Name of School, Practice/Group	Address of School/Facility, Practice/Group
/	/		
Date From (mm/yyyy)	Date To (mm/yyyy)	Name of School, Practice/Group	Address of School/Facility, Practice/Group
/	/		
Date From (mm/yyyy)	Date To (mm/yyyy)	Name of School, Practice/Group	Address of School/Facility, Practice/Group
/	/		
Date From (mm/yyyy)	Date To (mm/yyyy)	Name of School, Practice/Group	Address of School/Facility, Practice/Group
/	/		
Date From (mm/yyyy)	Date To (mm/yyyy)	Name of School, Practice/Group	Address of School/Facility, Practice/Group
/	/		

NOTE: **An explanation must be included for any gaps in your work history.** You may use this page or attach a separate page if needed.	

Save, (reminder to sign page 9 if you do not use CAQH), attach and email ENTIRE FORM to:
ProviderApps@dominionnational.com or fax to BlueDental Administrator at 1-888-345-2040.
Call 1-888-271-7806 with questions.

SUBMIT

If you have any questions regarding the contracting process, please contact **BlueDental Provider Network Relations at 1-888-271-7806.**

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