Provider Membership/Credentialing Application

TDA
Total Dental Administrators

Plans Applying For:
☐ PPO ☐ DHMO

PROVIDER INFORMATION

Last Name:	First Name:	MI:	DDS: ☐ DMD: ☐
Provider NPI Number:	Provider SSN:	DOB:	Gender: Male ☐ Female ☐
Dental School:		State:	Year:
Board Certified:* Yes: ☐ No: ☐	Name of Certifying Board:		
Specialty:	Name of Specialty Training Institution:	State:	Year:
State License #:*	License EXP:	DEA #:*	DEA EXP:
Malpractice Carrier:*	Malpractice Policy #:	Malpractice EXP:	Limits:	Medicaid #(if applicable):
Provider Email:	Languages Spoken:		

Five Year Work History - Chronological including current employer. Explain any gaps greater than six (6) months

Date From	Date To	Place

OFFICE INFORMATION

Office Name:			TIN (**W9 Required**):	Office NPI:
Office Street Address:				Office Manager:
City:	State:	Zip:	Website:	
Office Phone:	Office Fax:		Office Email:	
Office Hours: Monday:	Tuesday:	Wednesday:	Thursday:	Friday: Saturday Sunday:
Minimum Patient Age:	Maximum Patient Age:	In house lab? Yes: ☐ No: ☐	Handicap Accessible? Yes: ☐ No: ☐	

REQUIRED ITEMS:

☐ DEA Certificate ☐ W9 ☐ Signed Contract ☐ Signed Application ☐ License Copy ☐ Malpractice ☐ Specialist Cert (if applicable)

*Please include a copy

Internal Use Only:
SH _____

PRV _____

Return Address: Total Dental Administrators, Inc.
2800 N 44th St Suite 500
Phoenix, AZ 85008
Fax: 602.266.1948 Email: tdacredentialing@emihealth.com

Total Dental Administrators

Provider Name:

OFFICE INFORMATION CONTINUED

Billing Address (If different from Office Address):		
Billing City:	Billing State:	Billing Zip:
Billing Phone:	Billing Fax:	Billing Email:

ADDITIONAL OFFICE INFORMATION

Office Name:			TIN (**W9 Required**):	Office NPI:
Office Street Address:				Office Manager:
City:	State:	Zip:	Website:	
Office Phone:	Office Fax:		Office Email:	
Office Hours: Monday:	Tuesday:	Wednesday:	Thursday:	Friday: Saturday Sunday:
Minimum Patient Age:	Maximum Patient Age:	In house lab?	Yes: ☐ No: ☐	Handicap Accessible? Yes: ☐ No: ☐

Office Name:			TIN (**W9 Required**):	Office NPI:
Office Street Address:				Office Manager:
City:	State:	Zip:	Website:	
Office Phone:	Office Fax:		Office Email:	
Office Hours: Monday:	Tuesday:	Wednesday:	Thursday:	Friday: Saturday Sunday:
Minimum Patient Age:	Maximum Patient Age:	In house lab?	Yes: ☐ No: ☐	Handicap Accessible? Yes: ☐ No: ☐

Office Name:			TIN (**W9 Required**):	Office NPI:
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Office Phone:	Office Fax:		Office Email:	
Office Hours: Monday:	Tuesday:	Wednesday:	Thursday:	Friday: Saturday Sunday:
Minimum Patient Age:	Maximum Patient Age:	In house lab?	Yes: ☐ No: ☐	Handicap Accessible? Yes: ☐ No: ☐

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ATTESTATION

1. Have you ever had any of the following items voluntarily or involuntarily denied, Revoked, suspended, terminated, not renewed, placed under probation, subjected to disciplinary action, sanctioned, or otherwise limed or curtailed:		
Dental License in any state within the past five years?	Yes: ☐	No: ☐
DEA certificate or other narcotic registration?	Yes: ☐	No: ☐
Hospital or other health care facility staff membership or privileges?	Yes: ☐	No: ☐
Professional organization membership	Yes: ☐	No: ☐
Medicare, Medicaid, or other government program participation	Yes: ☐	No: ☐
Dental or health plan participation	Yes: ☐	No: ☐
Board certification?	Yes: ☐	No: ☐
2. Have any items above been voluntarily relinquished or pending currently?	Yes: ☐	No: ☐
3. Has your professional liability insurance ever been denied, suspended, canceled or not renewed?	Yes: ☐	No: ☐
4. Have you ever been subject of a peer review?	Yes: ☐	No: ☐
5. Have you ever been employed as a dentist or other provider by a military service, hospital, HMO, or any other health care organization?	Yes: ☐	No: ☐
If so was your employment ever terminated by the employer?	Yes: ☐	No: ☐
6. Have you ever been subject to any findings (i.e., letters of guidance, censure admonition etc.) by a State Board of Dental Examiners?	Yes: ☐	No: ☐
7. Do you now have, or within the last five years had, any physical condition, mental condition, substance or chemical dependency condition that does or has interfered with your ability to practice dentistry with or without accommodation?	Yes: ☐	No: ☐
8. Are you now or have you within the last two years received treatment or been advised to receive treatment for alcohol or other substance or chemical dependency?	Yes: ☐	No: ☐
9. Have you ever been convicted of a crime (other than a traffic offense,) or are you currently under investigation or indictment for an alleged crime?	Yes: ☐	No: ☐
10. Has any malpractice claim, settlement, judgment, or arbitration ever been paid by you or paid on your behalf?	Yes: ☐	No: ☐
11. Do you have any pending malpractice, arbitration, or State Board issues?	Yes: ☐	No: ☐
12. Do you have any chronic communicable disease or other medical conditions that would pose a risk to the safety or well being of your patients?	Yes: ☐	No: ☐

13. Do you have any limitations for which reasonable accommodation is necessary in order to perform the essential and/or marginal duties of your job?	Yes: ☐	No: ☐
14. Has all clinical staff been vaccinated for Hepatitis B or signed a waiver?	No: ☐	Yes: ☐
15. Does your office meet all Federal and State requirements, including ADA, OSHA and CDC infection control recommendation guidelines?	No: ☐	Yes: ☐

Use a separate piece of paper to give details for any "yes" response(s) to questions 1-12.

I attest that the information contained in this application is correct and complete. From here forward the Plan and Total Dental Administrators, Inc. and their authorized credentialing agents or associates will be know as the Plan. I, the undersigned, agree and authorize the Plan to do all necessary investigation to determine the above information, specifically but not limited to, my professional qualifications. I also authorize the Plan to disclose necessary information about me directly pertaining to the above information. I release the Plan and everyone involved from any liability connected with the release of such information so long as the party(ies) involved was (were) acting in good faith without malice. The undersigned agrees to notify the Plan of any changes in the above information within 10 days. The undersigned further understands that the intentional submission of false or misleading information or the withholding of relevant information is grounds for immediate termination from the Plan.

Applicants Signature

Date: