New provider application | Dental

Please complete all sections of the application in its entirety. Approximate length of time to complete is 5 minutes. Forms submitted with incomplete and/or missing information will delay the processing of your request.

☐ Adding a new provider to the network

1. **New provider application:**
   Complete **each** section of the form with indication Not Applicable (N/A) where appropriate. Please include an explanation in the Comment Section describing the changes you are requesting. Provide a list of additional locations the provider will be affiliated with including the TIN/EIN and group billing NPI.

   *If provider is practicing in multiple states, license verification is required for each state.

2. **Participating provider agreement:**
   Participation in the Arkansas Blue Cross PPP network is required. You may also participate in any additional networks. Please complete the attached Network Selection Addendum.

   ☐ Adding ArkansasBlue Medicare
   ☐ Adding PPO

3. **Attach photocopies of the following:**

   ✔ License
   ✔ DEA
   *(Drug Enforcement Administration) DEA Waiver required if DEA in process or provider does not hold DEA
   ✔ Professional Liability Insurance
   *which specifies the limits of liability (copy of insurance invoice or binder is not acceptable)
   ✔ CV (work history)
   *include dates and explanations for any significant gaps (more than 6 weeks) in your work history
   ✔ Diploma
   ✔ Specialty Training Certificate if applicable
   ✔ IRS Form CP575 or 147C with the practice information
   ✔ PMP proof of approved registration
   *(Arkansas Prescription Monitoring Program)

Any questions may be directed to **dentalproviderrelations@usablelife.com**. You will receive a letter confirming your effective date.

Application to join our dental networks

Section 1 | Personal information

Dentist's first name	MI	Last name	Suffix	Degree

Date of birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female	Social Security number

Dentist's individual type 1 NPI	Specialty

License number	State of license	Expiration date	DEA number	Expiration date

Non-DEA Holders Only select and complete either 1 or 2 as appropriate:

☐ 1. I do not have a valid DEA/CDS certificate. Prescribing substances is within the scope of my practice, and I have a designated practitioner in place to write prescriptions on my behalf. The name of the designated alternate prescriber is: _____

☐ 2. In my professional judgment, the patients receiving my care do not require controlled substances and I am therefore not required to have a DEA/CDS certificate. My process for handling instances when a patient requires a controlled substance is: _____

Specialty board certified status ☐ No ☐ Certified ☐ Eligible ☐ N/A	Board certification (if applicable) effective and expiration dates to

Education: General practice

School	Location	Date graduated (mm/yy)

Education: Specialty training

School	Location	Date graduated (mm/yy)

The following optional questions are included to meet National Committee for Quality Assurance (NCQA) standards. Providing this information is voluntary and will not affect the evaluation of your application.

Race	Ethnicity	Languages spoken

No aspect of network participation shall be denied based on origin, religion, national identity, gender, age or sexual orientation. We do not discriminate or base credentialing decisions on an applicant's race, ethnicity, or language.

Section 2 | Office and billing information

Practice name (as shown on CP575 or 147C)	Practice TIN

Type ☐ Group ☐ Individual ☐ Sole proprietor	Group name (if applicable)	Group type 2 NPI

Primary practice location phone number	Primary practice location fax number

Email address	Website

Physical address	**City**	**State**	**ZIP**
Billing address (if different than physical address)	**City**	**State**	**ZIP**
Mailing address (if different than physical address)	**City**	**State**	**ZIP**

Languages (including Sign Language) **spoken by provider, staff or interpreter:**

☐ **Yes** ☐ **No** Does your office have TDD service for patients with hearing impairments?

☐ **Yes** ☐ **No** Is your office accessible by public transportation?

☐ **Yes** ☐ **No** Is your office handicapped accessible?

☐ **Yes** ☐ **No** Does your office have weeknight hours?

☐ **Yes** ☐ **No** Does your office have weekend hours?

Section 3 | Work History

Beginning with your current location, please provide an up-to-date professional work history for the past five (5) years. Remember to include month and year for each entry. Please include dates and explanations for any significant gaps (more than 6 weeks) in your work history. Use an additional page if needed.

Current Practice

Name				**Start date** (mm/yy)
Address	**City**	**State**	**ZIP**	**Phone**

Immediate preceding practice or activity

Name			**Start date** (mm/yy)	**End date** (mm/yy)
Address	**City**	**State**	**ZIP**	**Phone**

Comments

Immediate preceding practice or activity

Name			**Start date** (mm/yy)	**End date** (mm/yy)
Address	**City**	**State**	**ZIP**	**Phone**

Comments

Immediate preceding practice or activity				
Name		**Start date** (mm/yy)	**End date** (mm/yy)	
Address	**City**	**State**	**ZIP**	**Phone**

Comments

Section 4 | Practice History (This section must be completed by the applicant)

Please complete the questions below regarding your malpractice history. **For each yes answer, please attach a detailed explanation.**

☐ Yes ☐ No	1.	Have there been or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice?
☐ Yes ☐ No	2.	Has your license to practice dentistry in any jurisdiction ever been denied, limited, suspended, revoked,or otherwise conditioned?
☐ Yes ☐ No	3.	Has your membership in any local, state or national professional society or organization ever been revoked or suspended? Are revocation or suspension activities presently pending, or have been denied membership or renewal in any such society or organization?
☐ Yes ☐ No	4.	Has your medical membership, medical privilege, or medical staff status at any hospital been granted with limitations, suspended, revoked, not renewed, denied, or subject to probationary conditions, or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
☐ Yes ☐ No	5.	Have you had any loss or limitation of privileges or disciplinary actions?
☐ Yes ☐ No	6.	Has your controlled substance registration ever been denied, revoked, suspended, reduced or not renewed: or have proceedings towards those ends ever been instituted or are presently pending?
☐ Yes ☐ No	7.	Have you been denied membership or renewal thereof, or been subjected to disciplinary action by any dental organization?
☐ Yes ☐ No	8.	Have you been the subject of any BCBS, Medicare, Medicaid (any state) or other dental reimbursement plan suspension or probation proceedings, or restricted from receiving payments from any BCBS, Medicare, Medicaid (any state), or other third-party programs?
☐ Yes ☐ No	9.	Have you been the subject of any disciplinary actions by state or local dental societies, any state board of registration or examiners, or the DEA?
☐ Yes ☐ No	10.	Have you ever been convicted of a felony, or are felony proceedings or indictments presently pending?
☐ Yes ☐ No	11.	Have you ever been denied professional liability insurance, or have you ever had professional liability insurance canceled?
☐ Yes ☐ No	12.	Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice dentistry in a competent, ethical and professional manner?
☐ Yes ☐ No	13.	Are you currently using illegal drugs that could affect your ability to practice dentistry?

Oral surgeons only

☐ **Yes** ☐ **No** Do you have any hospital privileges and/or affiliations? IfYes, please list all current privileges and/or affiliations?

Hospital name	**City**	**State**	**Start date** (mm/yy)

Medicare participation

☐ **Yes** ☐ **No**

Required attachments for all

Attach photocopies of:

☐ Professional liability insurance certificate (current)
☐ State license (current)
☐ DEA registration
☐ Specialty board certificate
☐ Permits for anesthesia (as applicable for oral surgeons)
☐ Curriculum vitae
☐ Prescription monitoring registration

AFFIRMATION AND CONSENT TO RELEASE INFORMATION To be completed by all applicants

Affirmation Statement
I (the "Applicant") represent that the information set forth in this Dentist Application (this "Application") is and shall remain true, accurate and correct in all material respects throughout the period during which USAble Life evaluates my Application and, if it accepts me as a Network Dentist, in accordance with the term of the Dental Network Participation Agreement ("Agreement").

The Applicant acknowledges and agrees that s/he shall notify USAble Life in a timely manner of any material changes in the information set forth in this Application occurring during the evaluation period and, if applicable, the term of the Agreement. The Applicant acknowledges that USAble Life may reject this Application or terminate the Agreement if it: (1) discovers any material omission or misstatement concerning any of the information set forth in this Application or (2) it is subsequently notified of a material change in such information.

If USAble Life, in its sole discretion, accepts the applicant as a Network Dentist, this Application shall be attached to and incorporated into the Agreement. The Dentist acknowledges and agrees that the Agreement shall be binding upon the parties only on and after its Effective Date, which shall be the date upon which the Agreement is signed by a representative of USAble Life.

Consent to Release Information
All information submitted by me in this application is true to my best knowledge and belief. I understand that this application does not create any right or expectation that I will be accepted by USAble Life as a Network Dentist.

I authorize USAble Life and its Representatives to consult with persons or entities ("Persons") to obtain and verify information concerning my professional competence, conduct, character, moral and ethical qualities, experience or other any other matters that USAble Life deems to be relevant in evaluating my Application (my "Qualifications"). I release USAble Life, such Persons and their respective Representatives from any and all liability for any and all non-malicious acts or omissions arising from or related to the provision, receipt, verification or evaluation of information pertaining to my Qualifications to become a Network Dentist.

I consent to permit Persons contacted by USAble Life or its Representatives to release any and all information or documents to USAble Life that it, in its discretion, may find relevant to an evaluation of my Qualifications, including without limitation: information or documents relating to any disciplinary action, suspension or curtailment of my license or privileges; and reports or summaries by professional liability insurance carriers relating to my insurance coverage's and or professional liability loss experience

I acknowledge that I have the burden of demonstrating my Qualifications to serve as a Network Dentist both now and in the future. Any dispute related to this Application shall be resolved in accordance with the Dispute Resolution Procedure section of the Dental Manual and, if USAble Life substantially prevails in any action pursuant to that Procedure, I shall reimburse USAble Life for any and all expenses incurred in connection with that action, including its attorneys' fees.

This Consent shall remain in full force and effect and may be relied on by those Persons providing information to USAble Life unless and until it is specifically revoked by me in writing. Any such revocation shall not apply retrospectively. A photocopy of this authorization shall be as effective as the original when presented.

Dentist

By (print name)		**Title**		
Primary physical address	**City**	**State**	**ZIP**	**Phone**
Email				
Signature		**Date of signature**		

Return completed form to:

Arkansas Blue Cross and Blue Shield
ATTN: Dental Provider Relations
PO Box 1650
Little Rock AR 72203

or

Fax: 501-208-8302
Email: dentalproviderrelations@usablelife.com

Appendix B | Locations covered by the agreement

The following locations fall under the purview of this Agreement (use additional sheets if needed):

Provider name	**NPI type 1**
Signature	**Date of signature**

Primary location

Name	**Type 2 NPI**	**Tax ID number**

Address	**City**	**State**	**ZIP**

Phone	**Fax**	**Email**

List any secondary locations below

Name	**Type 2 NPI**	**Tax ID number**

Address	**City**	**State**	**ZIP**

Phone	**Fax**	**Email**

Name	**Type 2 NPI**	**Tax ID number**

Address	**City**	**State**	**ZIP**

Phone	**Fax**	**Email**

Name	**Type 2 NPI**	**Tax ID number**

Address	**City**	**State**	**ZIP**

Phone	**Fax**	**Email**

Name	**Type 2 NPI**	**Tax ID number**

Address	**City**	**State**	**ZIP**

Phone	**Fax**	**Email**

Name	**Type 2 NPI**	**Tax ID number**

Address	**City**	**State**	**ZIP**

Phone	**Fax**	**Email**

Name	**Type 2 NPI**	**Tax ID number**

Address	**City**	**State**	**ZIP**

Phone	**Fax**	**Email**