Guardian®

Centralized Credentialing Provider Application

Attestation and Authorization Release Form

I attest that all the information provided in my Application is true and complete to the best of my knowledge and belief. I will notify The Guardian (as defined below) within 10 days of any material changes to the information I have provided or authorized to be released on my behalf. I understand that corrections to my Application are permitted at any time prior to the determination by Guardian and must be submitted on-line or in writing and must be dated and signed by me.

I authorize The Guardian Life Insurance Company of America on behalf of itself and any of its subsidiaries, including: Access Dental Plan, Access Dental Plan of Nevada, Inc., Access Dental Plan of Utah, Inc., Avēsis Incorporated, Avēsis Third Party Administrators, Inc., First Commonwealth, Inc., First Commonwealth Insurance Company, First Commonwealth Limited Health Services Corporation, First Commonwealth Limited Health Services Corporation of Michigan, First Commonwealth of Illinois, Inc., First Commonwealth of Missouri, Inc., Managed Dental Care, Managed DentalGuard, Inc. (New Jersey), Managed DentalGuard, Inc. (Ohio), Managed DentalGuard, Inc. (Texas) and Premier Access Insurance Company, affiliates, successors, employees, contractors, agents, anyone with whom such entities may contract and to whom information on any Application I submit for credentialing purposes may be released on an ongoing and continuing basis (collectively, "Guardian") to obtain information from others, including but not limited to: state licensing authorities, certification boards, the National Practitioner Data Bank (NPB), professional liability and malpractice insurance carriers (including claim histories and loss reports), hospitals, substance abuse programs, members of medical or other professional staffs, hospital administrators and health-care-related employers that may be necessary to evaluate my qualifications, including without limitation, my professional competence and conduct, information about disciplinary actions and information that might otherwise be considered confidential or privileged (collectively, "Credentialing Information").

I authorize Guardian to request and receive verification of Credentialing Information and authorize Guardian to monitor my credentials on an ongoing and continuing basis. I understand that I have the burden of providing adequate and accurate information to demonstrate my qualifications and that statements written on my Application will be considered statements made by me, even if prepared by another, including but not limited to an employee, agent or representative.

I attest that the information contained in my Application is correct and complete and understand that any misstatement or omission may constitute grounds for rejection of my Application or dismissal as a Participating Provider with Guardian or its client-sponsored networks. I understand that it is my ongoing obligation to immediately notify Guardian: (i) of any changes to the information provided in my Application (including but not limited to changes to professional liability insurance, malpractice status, physical or mental condition, or state dental license status), or (ii) if I have reason to believe or become aware that any information provided is inaccurate or inadequate. I understand that if Guardian denies my Application or otherwise takes action that is averse to my request for participation, Guardian may be obligated, under applicable law, to report such action to the NPDB and/or other licensing or accreditation agencies. I authorize Guardian to disclose all Credentialing Information to its members, payor clients or other entities who may lease a Provider Network from Guardian, subject to applicable law, rules and regulations. I understand that credentialing requirements may vary from state to state and additional information may be required. I release Guardian from all liability for acts performed in good faith and without malice. I agree that a digital image of my Application including this Form, as executed, shall be considered as a true and correct original and admissible as best evidence to the extent permitted by a court with proper jurisdiction.

Print Provider's Full Name	
Provider's Original Signature	**Date**

Note: Stamped signatures will not be accepted