Guardian

Dental Network Application Checklist

Please complete and return this document to ensure efficient processing of your application.

What Networks are You Interested in Joining?

- ☐ Dental Guard PPO (available in all states)
- ☐ Guardian DHMO (available in CA, CO, CT, FL, IL, IN, MI, MO, NJ, NY, OH, TX)
- ☐ CHIP ☐ Medicare ☐ Medicaid

Be Sure That:

- ☐ **Each dentist** has completed the Centralized Credentialing Application
- ☐ **All sections** of the form are filled out completely
- ☐ **Your SSN, Date of Birth and NPI** are included (even if you submit claims under a different number)
- ☐ **The Tax ID Number you use to submit claims** is included for each location
- ☐ **Thorough explanations** are given for any YES answers to Questions 1-22
- ☐ **Your Signature and Date** appear on the Professional Claims History (p. 10) and Attestation (p. 13)

Include Copies of the Following Documents:

- ☐ **Professional Liability Insurance Declaration Page** (not general insurance)
- ☐ **Current DEA Certificate (or DEA waiver) and CDS Certificate** as applicable
- ☐ **Current state(s) dental license(s)**
- ☐ **Specialty Certificate** as applicable
- ☐ **W-9** (2018 version or later)
- ☐ **Signed and Dated Agreement** – please include a list of all locations that should be considered in-network

GOVERNMENT BUSINESS PLEASE ALSO INCLUDE:

- ☐ Americans with Disabilities Act Survey
- ☐ Disclosure of Ownership (DOO)
- ☐ Provider Roster

FOR DHMO PLEASE ALSO INCLUDE:

- ☐ Associate Acknowledgement Form (General Dentist only)
- ☐ In CALIFORNIA ONLY, Economic Profile Form

To ensure timely processing, please send information directly to our Network Services Department.

You may e-mail PPO and DHMO applications to PPO_RC_Dental@glic.com and CHIP/Medicare/Medicaid applications to credentialingdept@avesis.com.

You may also fax all forms to **509-464-8019** or mail to:
DentalGuard Networks, P.O. Box 981574 El Paso, TX 79998

If you have questions or need additional forms, please call **866-229-1970.**

GUARDIAN DENTAL NETWORKS

CENTRALIZED CREDENTIALING PROVIDER APPLICATION

Centralizing credentialing across our enterprise is just another way we are making it easier to do business with us.

This application will be processed by Guardian Life Insurance Company of America ("Guardian"). Serving as the guardian of your credentials, all communications regarding this application and future credentialing events will be communicated to you by Guardian and shared only with those Guardian companies where you have expressed an interest in becoming a participating provider or have an existing contractual relationship.

THE GUARDIAN INSURANCE COMPANY OF AMERICA P.O. Box 981574 El Paso, TX 79998-1574

General Information

Please complete all relevant fields.

First Name	Middle Name	Last Name	Suffix	Degree Title

Contact Email Address	Fax

Gender			Social Security Number
☐ Male	☐ Female	☐ Other	
Birth Date			**NPI-1**
Medicare Number			**Medicaid Number**

Home Address

Please enter your home address in full.

Home Address Line 1
Home Address Line 2

City	State	Zip

Other Names

Please enter any other names by which you have been known.

First Name	Middle Name	Last Name	From Date	To Date

Licensure

Please list all current and past licenses.

License Type	License Number

License Status		
☐ Active	☐ Inactive	☐ Expired

State	Issue Date	Expiration Date

License Type	License Number

License Status

State	Issue Date	Expiration Date

DEA Registration

Please provide details of all DEA registrations.

DEA Number	Status

State	Issue Date	Expiration Date

DEA Number	Status

State	Issue Date	Expiration Date

Controlled Substance Certificate

Please provide details of all CSC registrations.

Number		Status
State	**Issue Date**	**Expiration Date**

Anesthesia Permit

Please provide details of all Anesthesia Permits

Number		Status
State	**Issue Date**	**Expiration Date**

ECFMG

Where applicable, please provide any Educational Commission for Foreign Medical Graduates details below.

Name on Certificate	ECFMG Number	Issue Date

Additional or Other Certification

Please provide details of any other certifications

Certificate Type		Certificate Number
State	**Issue Date**	**Expiration Date**

Certificate Type		Certificate Number
State	**Issue Date**	**Expiration Date**

Service Location

Please provide full details of any relevant office.

Address Type				
☐ Primary Practice Location	☐ Other Practice Location			
Practice Type				
☐ FQHC	☐ Mobile	☐ Indian Health Clinic	☐ Ryan White	☐ Family Planning
Practice Name				
Address Line 1				
Address Line 2				

City	State	Zip
Tax ID	**Phone**	**Fax**
Credentialing Contact	**Contact Phone**	**Contact Email**
Web Site URL		**Group NPI-2**

Credit Cards Accepted					
☐ American Express	☐ Care Credit	☐ Discover Card	☐ MasterCard	☐ Visa	☐ Other

Emergency & Patient Access Services							
Are emergency services available 24 hours a day?	☐ Yes	☐ No	Method of Access	☐ Answering Service	☐ Urgent Care	☐ Emergency Phone #	☐ Emergency Room
Accepts patients with Special Needs and/or disabilities?	☐ Yes	☐ No	TTY Available	☐ Yes		☐ No	
Handicap accessible office (ADA compliant)?	☐ Yes	☐ No	Handicap parking available?	☐ Yes		☐ No	
Provides or staff CPR certified?	☐ Yes	☐ No	Accepts new patients?	☐ Yes		☐ No	
Age of patients accepted	From		To				

Service Location (continued)

Please indicate practice capabilities

Endodontics	Anterior root canal treatment		**Oral Surgery**	Erupted tooth surgical removal	
	Bicuspid root canal treatment			Impaction tooth removal	
	Molar root canal treatment		**Periodontics**	Surgical periodontal services	
Restorative	Amalgam restorations			Scaling and root planning	
	Composite restorations		**Pediatric Dentistry**	Routine care < 8 years old	
				Routine care > 8 years old	

Please indicate which services are offered at this location.

Nitrous Oxide	☐ Yes	☐ No	
General Anesthesia	☐ Yes	☐ No	
IV Sedation	☐ Yes	☐ No	
Oral Sedation	☐ Yes	☐ No	
Panoramic X-ray	☐ Yes	☐ No	
Intraoral X-ray	☐ Yes	☐ No	
Electronic claim submission	☐ Yes	☐ No	
Digital radiograph submission	☐ Yes	☐ No	
Sterilization method	☐ Auto clave	☐ Chem clave	☐ Other

Please indicate all non-English languages spoken at this location.

Language 1	Language 2	Language 3

Please provide the hours during which you practice at this location

	AM Open	AM Close	PM Open	PM Close
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Correspondence Address

Please indicate the address you would like all written communications mailed to.

Practice Name		
Address Line 1		
Address Line 2		
City	**State**	**Zip**
Tax ID	**Phone**	**Fax**
Office Manager		**Phone**
Office Manager's Email Address		

Billing Address

Please indicate the address you would like all payment remittances mailed to.

Practice Name		
Address Line 1		
Address Line 2		
City	**State**	**Zip**
Tax ID	**Phone**	**Fax**
Billing Manager		**Phone**
Billing Manager's Email Address		

Provider Specialty

Please indicate area of practice **if other than General Dentist**.

Primary Specialty

Board Certification ☐ Not Applicable

Please complete all relevant fields.

Name of Board		
Board Status	**Lifetime Certified**	
	☐ Yes	☐ No
Certification Date	**Expiration Date**	

Education

Please complete all relevant fields. Allied Health Professionals must include undergraduate education.

Education Type			Degree Earned
☐ Undergraduate	☐ Graduate	☐ Post Graduate	
Institution Name			**Date From -To (MM/YYYY format)**
Address Line 1			
City	**State**	**Zip**	**Country (if non-US)**

Education Type			Degree Earned
☐ Undergraduate	☐ Graduate	☐ Post Graduate	
Institution Name			**Date From -To (MM/YYYY format)**
Address Line 1			
City	**State**	**Zip**	**Country (if non-US)**

Work History

Please list all places of clinical practice and/or employment since completion of training, over the last ten years. Please begin with the most current and list in chronological order. Please explain any gaps greater than six (6) months or more on a separate piece of paper. ***If practicing in Georgia, Illinois or Pennsylvania, please explain any gaps in work history greater than thirty days (30-days).***

Date From/To (MM/YY format)	Employer	Address (City, State)	Phone	Can employer to contacted?	
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No

Work Gap Explanation:

From/To (MM/YY format)	Explanation

Liability Insurance

Please list all professional liability insurance carriers, including any tort or patient compensation fund programs. ***A current copy of the professional liability coverage, including the amounts, policy dates and provider's name for each policy listed below must be submitted with this application.***

Carrier Name	
Policy Number	**Coverage Type**
Effective Date	**Expiration Date**
Per Claim Limit	**Aggregate Limit**

Carrier Name	
Policy Number	**Coverage Type**
Effective Date	**Expiration Date**
Per Claim Limit	**Aggregate Limit**

Professional Claims History

Do you have, or have you ever had any claims of malpractice which have been commenced against you, whether closed or currently open?	☐ Yes	☐ No
Please indicate the number of separate claim explanations submitted with this application:		
If you indicated that you have any claims, please complete a separate Professional Liability Claims information section for each open or closed claim. Please copy that page for each additional claim you have. By signing below, you acknowledge that you have no claims to disclose or that the number of claims indicated above is correct.		

Provider's Original Signature *Date*

Professional Liability Claims Information

Please provide a detailed explanation below for each open or closed. Copy this page for each additional claim you have.

NOTE: Explanation must be provided by the Practitioner, NOT the insurance company or attorney.

CLAIM NUMBER _____ OF _____:

Reporting Institution Name or Claimant				
Date of Incident	**Date Claim Filed**	**Claim Status**		
		☐ Pending	☐ Settled	☐ Dismissed
Description of Case				
Provider Statement				
Judgement Description				
Judgement Date	**Judgement Amount**			
Provider Signature	**Date**			

Attestation Questions

Please answer each of the following questions. Any question answered adversely will require a detailed explanation.

	Yes	*No*
1. Have any of the following ever been or are currently under investigation, either on a voluntary or involuntary basis (e.g., denied, revoked, suspended, probated, not renewed)?		
a. Medical license in any state or jurisdiction		
b. Other professional registration/license in any state or jurisdiction		
c. Federal DEA Registration		
d. State Controlled Substance Registration		
e. Membership on any hospital/healthcare facility medical/professional staff		
f. Clinical Privileges		
g. Participation in the Medicare/Medicaid program(s)		
h. Membership in other health care organizations or plans (PHO, MSO, HMO, ASC)		
i. Professional society membership		
j. Board Certification		
k. ECFMG Certification		
l. Prerogatives/rights on any medical staff		
m. Any other type of professional sanction		
2. Have you ever pled guilty, pled no contest, been convicted or are presently indicted for a felony?		
3. Have you ever been arrested (even if the record has been expunged)?		
4. Have there ever been any misdemeanor/felony criminal charges brought against you?		
5. Has any claim of sexual harassment or violation of civil rights ever been made against you that resulted in you receiving or incurring any warning, disciplinary action, or civil liability?		
6. Have you ever been denied professional liability insurance or has your coverage ever been canceled or not renewed?		
7. Has any professional liability insurance carrier excluded any specific procedures from your coverage or advised you that it intends to terminate, reduce, or otherwise restrict your coverage?		
8. Are there any privileges you are requesting which are not covered by your professional liability insurance?		
9. Have any professional liability suits filed resulted in a judgment against you or been terminated pursuant to a settlement in which you have paid damages to the plaintiff, with or without admitting liability?		
10. Have you ever settled any professional liability claim against you prior to suit and admitted liability as part of such settlement?		
11. Are you now or have you ever engaged in the illegal use of controlled substances?		
12. Are you currently or have you ever participated in a supervised rehabilitation program or professional assistance program as a patient?		
13. Has a suit been filed against an institution or entity based upon alleged negligent medical acts or omissions by you within the last ten years (even if dismissed or dropped), other than identified above (e.g. a suit against a teaching hospital, university, governmental entity or other employers)?		
14. Has a settlement been made by an institution based upon alleged negligent medical acts or omissions by you within the last ten years?		
15. Are you currently, or have you ever been, the subject of an individual focused review by a health care facility's Quality Assurance, Utilization Review, Risk Management, Peer Review or similar monitoring committee?		
16. Has any professional review organization under contract with Medicare or Medicaid ever made an adverse quality determination concerning your treatment rendered to any patient?		
17. Have you at any time during the last 10 years been hospitalized or received any other type of institutional care for physical/mental problems?		
18. Do you have a condition that could compromise your ability to perform any of the mental and physical functions related to the specific clinical privileges you are requesting?		
19. In the last five (5) years, have you had any gaps of six (6) months or greater, where you did not work as a practitioner in this current discipline? If "YES," please explain the reason(s) for any gap(s) on a separate page.		
20. Do you monitor your staff member's licenses to verify the licenses are current and without encumbrance?		
21. Do you and your staff complete fraud, waste and abuse training upon hire and annually thereafter? If no, do you participate in Medicare or Medicaid programs? Yes No		
22. Do you and your staff complete cultural competency training upon hire and annually thereafter? If no, do you participate in Medicare or Medicaid programs? Yes No		

Attestation & Credentials Release of Verification

I attest that all information provided in this Application is true and complete to the best of my knowledge and belief. I will notify the Organizations and/or their agents within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of membership and/or privileges or affiliation by the Organizations, and must be submitted on-line or in writing, and must be dated and signed by me.

I, the undersigned Provider, authorize The Guardian Life Insurance Company of America ("Guardian") , to whom information on this Application may be released on an ongoing and continuing basis, as well as to its affiliates, subsidiaries, successors, employees, contractors, agents and anyone with whom it may enter into a contract with (collectively, "Representatives") to obtain information from others, including but not limited to: state licensing authorities, certification boards, 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 Credential 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 this 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 this application is correct and complete and understand that any misstatement or omission on this application may constitute grounds for rejection of my application or dismissal as Participating Provider with Guardian's 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 (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 adverse 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 any and 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 any and all liability for acts performed in good faith and without malice in obtaining and verifying the information collected and evaluating my application. I agree that a digital image of this document, 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. **(Note: Stamped signatures will not be accepted).**

Print Provider's Full Name	
Provider's original signature	**Date**