

Teachers Health Trust Dental Network

The Teachers Health Trust (Trust) has developed its own PPO Dental Network for its members effective January 1, 2010.

The attached Dental Credentialing/Recredentialing Application is to be completed, provided you have already returned your interest form and received a contract proposal from the Trust. If you have not yet returned an interest form and received a contract proposal, please return to the Web page and download the interest form.

This credentialing application includes three pages. All pages of the document must be completed, signed, and dated. A separate application must be completed for each dental professional in your group. Be sure to complete the Malpractice Claim Information Worksheet, as it must be signed regardless of whether a dentist has had any malpractice claims or not.

Please send the three-page application with all the required supporting documents to the Trust either via facsimile at (702) 866-6121 or postal service at P.O. Box 96238, Las Vegas, Nevada 89193-6238, Attention: Provider Relations Department. The required documents are listed below:

- Current Dental License for the state in which you work
- Current State Pharmacy License
- Current Federal DEA
- Current Professional Liability Insurance
- Specialty Certificate (if applicable)
- Copy of W-9/EIN

If you have any questions or require additional information, please contact the Provider Relations Department at (702) 866-6120. You may also e-mail the Provider Relations Department at providerrelations@teachershealthtrust.org.



For Teachers By Teachers

Dental Credentialing/Recredentialing Application

Please ensure all fields are completed and that the form is signed and dated with a current date prior to submitting. Each dentist practicing in your group must fill out a separate CREDENTIALING INFORMATION FORM, and all providers in your group must complete credentialing before the group will be considered in-network.

Dentist's Name: Last: _____ First: _____ Middle: _____ Specialty: <input type="checkbox"/> Endodontia <input type="checkbox"/> General Dentist <input type="checkbox"/> Orthodontia <input type="checkbox"/> Pediatrics (Pedodontia) <input type="checkbox"/> Periodontia <input type="checkbox"/> Prosthodontia <input type="checkbox"/> Surgery (Oral or Maxillofacial) <input type="checkbox"/> Other _____	<input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> Other _____
Practice Name: _____ TIN: _____ <small>(Pay To Name)</small> EIN Name: _____ <small>(Business name on tax forms)</small> Dentist Start Date: _____ NPI: _____	Specialty: <input type="checkbox"/> Endodontia <input type="checkbox"/> General Dentist <input type="checkbox"/> Orthodontia <input type="checkbox"/> Pediatrics (Pedodontia) <input type="checkbox"/> Periodontia <input type="checkbox"/> Prosthodontia <input type="checkbox"/> Surgery (Oral or Maxillofacial) <input type="checkbox"/> Other _____
Have you had any Board actions or stipulations filed against you in ANY state? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please supply documentation from the Board as well as the details of each case on a separate page. Signature and current date is required. Have you had any malpractice claims filed against you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please supply court documents and the details of each case on the enclosed Malpractice Claim Information Worksheet. Have you been convicted of a criminal offense other than a minor traffic violation? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please provide an explanation with a current date and signature as well as supporting court documents.	Physical Address (This will be displayed in the Provider Directory.) 1 Address _____ City _____ State _____ Zip _____ Phone _____ Fax _____
List the states in which you have practiced in the past five years: _____ _____	Physical Address (This will be displayed in the Provider Directory.) 2 Address _____ City _____ State _____ Zip _____ Phone _____ Fax _____
Primary Language (other than English): _____ _____ E-mail: _____	Physical Address (This will be displayed in the Provider Directory.) 3 Address _____ City _____ State _____ Zip _____ Phone _____ Fax _____
Wheelchair accessible <input type="checkbox"/> Yes <input type="checkbox"/> No IV sedation <input type="checkbox"/> Yes <input type="checkbox"/> No General anesthesia <input type="checkbox"/> Yes <input type="checkbox"/> No Nitrous oxide <input type="checkbox"/> Yes <input type="checkbox"/> No	Credentialing Address (for credentialing dentist(s)): Address _____ City _____ State _____ Zip _____ Credentialing Contact Name _____ Phone _____ <input type="checkbox"/> Same as physical address <input type="checkbox"/> Same as mailing address
Wheelchair accessible <input type="checkbox"/> Yes <input type="checkbox"/> No IV sedation <input type="checkbox"/> Yes <input type="checkbox"/> No General anesthesia <input type="checkbox"/> Yes <input type="checkbox"/> No Nitrous oxide <input type="checkbox"/> Yes <input type="checkbox"/> No	Remit Address (insurance pay-to address): Address: _____ City _____ State _____ Zip _____ Billing Contact Name _____ Phone _____ <input type="checkbox"/> Same as physical address <input type="checkbox"/> Same as mailing address

Your request cannot be processed without current documents. Please attach copies of the following documents:

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|---|---|
| <input type="checkbox"/> Current Dental License for the state in which you work | <input type="checkbox"/> Current Professional Liability Insurance |
| <input type="checkbox"/> Current State Pharmacy License | <input type="checkbox"/> Specialty Certificate (if applicable) |
| <input type="checkbox"/> Current Federal DEA | <input type="checkbox"/> Copy of W-9/EIN |

Please allow at least sixty (60) days to process your application. Failure to sign, date, and promptly return ALL required documents and forms will result in a delay of your in-network status as well as that of your entire group.

STATEMENT OF UNDERSTANDING, AUTHORIZATION, CONSENT, AND RELEASE

I understand that any misrepresentation or significant omission in this application constitutes cause for denial or for subsequent revocation of membership in the Teachers Health Trust's provider network. I also have had an opportunity to review the information submitted in support of this application. If during the process of credentialing, the Teachers Health Trust's provider network receives information that varies substantially from information I have provided, I will be notified of this and will have an opportunity to correct erroneous information.

I recognize that, as the applicant, I bear the burden of demonstrating that I am qualified and remain qualified for the award of membership in accordance with the criteria and standards required by the Teachers Health Trust's provider network, and I recognize that I have the burden of resolving any reasonable doubts about my qualifications for membership, participation, and privileges.

In order to facilitate the evaluation of this application, I agree to meet and cooperate with the various officers, representatives, and committees charged with the responsibilities of credentialing and peer review activities. Moreover, I consent to the communication and release of information and documents (including staff records and patient care records) among the specified entities I have disclosed in this application as well as any and all other dental staffs, dental schools, training programs, societies, professional associations, professional liability insurers, licensing authorities, specialty boards, dental organizations, and any and all other sources that may be available for the purpose of evaluating my professional education, training, experience, character, conduct, and judgment. In this regard, care shall be taken to safeguard the privacy of dental information and the confidentiality of dental staff information and dental records. I understand that the evaluation of credentials shall be accomplished in a professional manner and that I will be afforded an appropriate review in the event that action on this application is adverse in accordance with the bylaws or rules pertaining to each organization.

I specifically authorize the transmission of this application, all supporting documentation, and all information collected during the credentialing process to each employee of the Teachers Health Trust responsible for reviewing my application.

I therefore fully release from liability any person or entity (including any and all representatives of the Teachers Health Trust and any representative, agent, or component thereof) that requests or provides information in connection with the evaluation of my application, credentials, and practice to the fullest extent allowed by applicable statutes, regulations, and judicial decisions. Moreover, I fully release from liability the Teachers Health Trust and any representative, agent, or component thereof, as well as all other persons or entities participating in the evaluation of my credentials and practice from any and all liability for their actions and decisions to the fullest extent allowed by applicable statutes, regulations, and judicial decisions. As part of this application, I pledge that, if I am granted the requested membership, I will maintain an ethical practice in accordance with applicable bylaws, and specifically, I will:

- A. Refrain from fee splitting or other inducements relating to patient referrals,
- B. Provide for the continuous care and supervision of my patients,
- C. Abide by all applicable and generally recognized ethical principles related to my profession and to each and every dental care entity to which I am applying; and
- D. Maintain the confidentiality of patient information received by both paper and electronic means.

During the time that this application is being processed, I agree to update the application should there be any material change in the information provided which may affect the application or its outcome; and, once credentialed, I specifically agree to notify the Teachers Health Trust immediately upon any significant change or any formally recommended change in licensure status; any actual or formally recommended denial, suspension, or revocation of privileges, membership, or status by another dental care entity; or cancellation or interruption of my professional liability insurance coverage.

I present this application and arrange for the submission of other information as part of this credentialing process in the expectation that the confidentiality and privacy of this information will be preserved and that this information and these materials will only be released and disclosed as part of current and future credentialing, peer review, and quality assurance processes as described above.

I affirm that all information submitted by me in this application is true, current, complete, and furnished in good faith.

Signature of Applicant

Printed Name

Date

MALPRACTICE CLAIM INFORMATION WORKSHEET

Sign and date this form regardless of whether you have any items to disclose.

Please provide complete information.

Please duplicate this form and complete for EACH case in which you were named as a defendant. Also, for each case that has been settled or dismissed, supply all court/legal documentation and sign and date all information provided.

Practitioner name:

Patient name:		
Diagnosis:		
Your involvement in the case:		
Allegations:		
Case summary (include additional pages or inserts if necessary):		
Patient outcome:		
Other pertinent details:		
Date of incident:	Date filed:	Date closed:
Current status of case must be noted (e.g., dismissed, settled out of court, pending, or other) Note: All cases must include legal documentation:		
Settlement amount paid on your behalf, if any:		
Professional liability insurer involved:		
Name of insurer:		
Address of insurer:		
Policy number:		

- I have no malpractice issues to disclose.
- I certify that I have disclosed all malpractice issues.

Print Practitioner's Name

Date

Signature