



Maryland Uniform Dental Credentialing Form

Instructions

Read all instructions carefully prior to submitting your application.

This form may be completed and sent electronically or in printed form.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another application or credentialing form.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Enter information legibly and inside the boxes and spaces provided.
4. Complete all sections that are applicable to you. Use supplemental forms where appropriate.
5. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 24-26.
6. Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1

Personal Information and Professional IDs

Provider Type

Code list is found on page 24. Enter the associated 3-digit code in the space provided.*

YES

NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?*

Name

Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME*

SUFFIX (JR, III)

FIRST NAME*

MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?*

YES

NO

IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME

SUFFIX (JR, III)

OTHER FIRST NAME

OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (MM/DD/YYYY)

DATE STOPPED USING OTHER NAME (MM/DD/YYYY)

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 25-27. Enter the associated 3-digit code in the space provided.

GENDER*

MALE

FEMALE

DATE OF BIRTH*

(MM/DD/YYYY)

CITY OF BIRTH

STATE OF BIRTH

COUNTRY OF BIRTH

SSN*

FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN)

FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

Home Address

NUMBER

STREET

APT NUMBER

CITY

STATE

ZIP CODE

TELEPHONE

NOTE: This information used for application follow-up.

E-MAIL

FAX

PREFERRED METHOD OF CONTACT*

E-MAIL

FAX

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1

Personal Information and Professional IDs (Continued)

Professional IDs

Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/certifications.

Non-licensed professionals should enter certification/registration number in the space provided for license number.

<input type="text"/>	<input type="text"/>
FEDERAL DEA NUMBER	DEA ISSUE DATE (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>
DEA STATE OF REGISTRATION	DEA EXPIRATION DATE (MM/DD/YYYY)

<input type="text"/>	<input type="text"/>
CDS CERTIFICATE NUMBER	CDS ISSUE DATE (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>
CDS STATE OF REGISTRATION	CDS EXPIRATION DATE (MM/DD/YYYY)

<input type="text"/>	<input type="text"/>	<input type="text"/>
STATE LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE ISSUE DATE (MM/DD/YYYY)
IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="text"/>
		LICENSE EXPIRATION DATE (MM/DD/YYYY)
<input type="text"/>	Provider Type Code List is found on Page 24.	
PROVIDER TYPE CODE		

<input type="text"/>	<input type="text"/>	<input type="text"/>
STATE LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE ISSUE DATE (MM/DD/YYYY)
IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="text"/>
		LICENSE EXPIRATION DATE (MM/DD/YYYY)
<input type="text"/>	Provider Type Code List is found on Page 24.	
PROVIDER TYPE CODE		

Other ID Numbers

Indicate all that apply.

ARE YOU A PARTICIPATING MEDICAID PROVIDER?* YES NO

<input type="text"/>	<input type="text"/>
MEDICAID NUMBER	MEDICAID STATE

<input type="text"/>	<input type="text"/>	<input type="text"/>
NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER	USMLE NUMBER (WITHOUT HYPHENS)	WORKERS COMPENSATION NUMBER

<input type="text"/>	<input type="text"/>
ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)	ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) (MM/DD/YYYY)

License Status

Indicate all that apply.

GENERAL DENTAL LICENSE <input type="checkbox"/> YES <input type="checkbox"/> NO	LIMITED DENTAL LICENSE <input type="checkbox"/> YES <input type="checkbox"/> NO
TEMPORARY DENTAL LICENSE <input type="checkbox"/> YES <input type="checkbox"/> NO	INACTIVE DENTAL LICENSE <input type="checkbox"/> YES <input type="checkbox"/> NO
TEACHER'S DENTAL LICENSE <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER LICENSE STATUS <input type="text"/> Status Code List is found on Page 24.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2

Education and Training

Undergraduate School

Provide the appropriate information for the school that issued your undergraduate degree.

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

START DATE (MM/YYYY)

END DATE (GRADUATION DATE)
(MM/YYYY)

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL?

 YES NO

DEGREE AWARDED

Professional School(s)

Provide the appropriate information for the school that issued your professional degree.

GRADUATE TYPE*:

 U.S. OR CANADIAN GRADUATE NON-U.S./CANADIAN GRADUATE FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./CANADIAN ONLY)

NAME OF U.S./CANADIAN SCHOOL:

START DATE* (MM/YYYY)

END DATE (GRADUATION DATE)*
(MM/YYYY)

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

 YES NO

DEGREE AWARDED

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY

COUNTRY CODE

POSTAL CODE

START DATE* (MM/YYYY)

END DATE (GRADUATION DATE)*
(MM/YYYY)

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?

 YES NO

DEGREE AWARDED

OTHER PROFESSIONAL SCHOOL

OFFICIAL NAME OF OTHER PROFESSIONAL SCHOOL

CITY

COUNTRY CODE

START DATE* (MM/YYYY)

END DATE (GRADUATION DATE)*
(MM/YYYY)

DEGREE AWARDED

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2

Education and Training (Continued)

Training

List all training programs you attended. Use one section per institution.

Professional School Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

		SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)
INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)		
NUMBER	STREET	SUITE/BUILDING
CITY	STATE	ZIP/POSTAL CODE
COUNTRY CODE	TELEPHONE	FAX
DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)		

List each department separately, if applicable.

List Internship/Residency, Fellowship and Other programs separately.

	<input type="checkbox"/> INTERNSHIP/ RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER		
				START DATE (MM/YYYY)	END DATE (MM/YYYY)
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)					
NAME OF DIRECTOR					
	<input type="checkbox"/> INTERNSHIP/ RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER		
				START DATE (MM/YYYY)	END DATE (MM/YYYY)
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)					
NAME OF DIRECTOR					
	<input type="checkbox"/> INTERNSHIP/ RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER		
				START DATE (MM/YYYY)	END DATE (MM/YYYY)
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)					
NAME OF DIRECTOR					

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3

Professional / Dental Specialty Information

Specialty Status

GENERAL DENTIST YES NO

SPECIALIST YES NO PRIMARY SPECIALTY

Primary Specialty

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE INITIAL CERTIFICATION DATE (MM/DD/YYYY) DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO YES NO

BOARD CERTIFIED? YES NO RECERTIFICATION DATE (IF APPLICABLE) (MM/DD/YYYY) PPO YES NO

CERTIFYING BOARD CODE EXPIRATION DATE (IF APPLICABLE) (MM/DD/YYYY) POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE) I HAVE TAKEN EXAM, RESULTS PENDING FOR I INTEND TO SIT FOR AN EXAM ON (MM/DD/YYYY) I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

CERTIFYING BOARD CODE

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Secondary Specialty

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE INITIAL CERTIFICATION DATE (MM/DD/YYYY) DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO YES NO

BOARD CERTIFIED? YES NO RECERTIFICATION DATE (IF APPLICABLE) (MM/DD/YYYY) PPO YES NO

CERTIFYING BOARD CODE EXPIRATION DATE (IF APPLICABLE) (MM/DD/YYYY) POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE) I HAVE TAKEN EXAM, RESULTS PENDING FOR I INTEND TO SIT FOR AN EXAM ON (MM/DD/YYYY) I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

CERTIFYING BOARD CODE

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Primary Credentialing Contact

CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION ON PAGE 7 AS THE CREDENTIALING INFORMATION.

LAST NAME

FIRST NAME M.I.

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP CODE

TELEPHONE FAX

E-MAIL ADDRESS (Even if you checked the boxes above, please provide the e-mail address, if available.)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 19-20.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE PRIMARY CREDENTIALING CONTACT QUESTION ON PAGE 5. SECTION 4 MAY BE LEFT BLANK AND YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

CURRENTLY PRACTICING AT THIS ADDRESS?* YES NO PREVIOUS OR FUTURE START DATE? (MM/DD/YYYY)

DENTAL GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* YES NO TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID PRIMARY TAX ID (ONE ONLY)* USE INDIVIDUAL TAX ID USE GROUP TAX ID

Office Manager or Business Office Staff Contact

List office staff and billing contacts separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME* M.I.

FIRST NAME*

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

NOTE: Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

LAST NAME* M.I.

FIRST NAME*

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information (Continued)

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* YES NO
 BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION

LAST NAME*

M.I.
 FIRST NAME*

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Payee Contact.

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	FRIDAY	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
TUESDAY	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	SATURDAY	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
WEDNESDAY	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	SUNDAY	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
THURSDAY	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>					

24/7 PHONE COVERAGE?* IF YES
 YES NO ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE VOICE MAIL WITH OTHER INSTRUCTIONS COVERING COLLEAGUE OTHER

CURRENT WAIT TIME FOR INITIAL APPOINTMENT NUMBER OF OPERATORIES AVAILABLE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO ACCEPT ALL NEW PATIENTS?* YES NO
 ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO ACCEPT NEW MEDICAID PATIENTS?* YES NO
 ACCEPT NEW PATIENTS WITH PROVIDER REFERRAL?* YES NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* YES NO IF YES, EXPLAIN

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information (Continued)

Mid-Level Practitioners

Identify the primary mid-level practitioners of your practice.

DO MID-LEVEL PRACTITIONERS CARE FOR PATIENTS IN YOUR PRACTICE?*

YES NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE
(E.G., ADHA, RDH, CDA, RDA, CDT)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE
(E.G., ADHA, RDH, CDA, RDA, CDT)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

PRACTITIONER TYPE
(E.G., ADHA, RDH, CDA, RDA, CDT)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information (Continued)

Languages

Code lists are found on pages 24-25. Enter the associated 3-digit code in the space provided.

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

BUILDING?* YES NO

PARKING?* YES NO

RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?*

YES NO

TEXT TELEPHONY (TTY)* YES NO

AMERICAN SIGN LANGUAGE* YES NO

MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

TDDY/HEARING IMPAIRED YES NO

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

OTHER TRANSPORTATION ACCESS

Certifications

DO YOU HOLD THE FOLLOWING CERTIFICATIONS? IF YES, PROVIDE EXPIRATION DATES.

BASIC LIFE SUPPORT YES NO

EXPIRATION DATE (MM/DD/YYYY)

CPR YES NO

EXPIRATION DATE (MM/DD/YYYY)

Services

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES?

RADIOLOGY SERVICES? YES NO

IF YES, TYPES OF X-RAY EQUIPMENT

INTRAORAL X-RAY UNIT YES NO

PANORAPHIC X-RAY UNIT YES NO

ANESTHESIA SERVICES? YES NO

IF YES, WHAT CLASS/CATEGORY DO YOU USE?

CONSCIOUS SEDATION? YES NO

NITROUS OXIDE? YES NO

IF YES, WHO ADMINISTERS IT?

LAST NAME

FIRST NAME

STERILIZATION METHODS USED AUTOCLAVE YES NO

CHEMCLAVE YES NO

OTHER YES NO

EXPLAIN

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE

SINGLE SPECIALTY GROUP

MULTI-SPECIALTY GROUP

CORPORATION

LLC

OTHER EXPLAIN

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Practice Location Information (Continued)

**Partners/
Associates**

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

<input type="text"/>			<input type="text"/>	<input type="checkbox"/>
LAST NAME			SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 24)	
<input type="text"/>	<input type="text"/>	<input type="text"/>		
STATE LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE ISSUE DATE (DD/MM/YYYY)		

<input type="text"/>			<input type="text"/>	<input type="checkbox"/>
LAST NAME			SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 24)	
<input type="text"/>	<input type="text"/>	<input type="text"/>		
STATE LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE ISSUE DATE (DD/MM/YYYY)		

<input type="text"/>			<input type="text"/>	<input type="checkbox"/>
LAST NAME			SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 24)	
<input type="text"/>	<input type="text"/>	<input type="text"/>		
STATE LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE ISSUE DATE (DD/MM/YYYY)		

DO YOU HAVE MORE THAN THREE PARTNERS/ASSOCIATES AT THIS PRACTICE? YES NO IF MORE THAN THREE, HOW MANY?

**Covering
Colleagues**

Code lists are found on pages 24-26. Enter the associated 3-digit code in the space provided.

LIST PRIMARY COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

<input type="text"/>			<input type="text"/>
LAST NAME			SPECIALTY CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 24)

<input type="text"/>			<input type="text"/>
LAST NAME			SPECIALTY CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME		M.I.	PROVIDER TYPE (CODE PG 24)

DO YOU HAVE MORE THAN TWO COVERING COLLEAGUES AT THIS PRACTICE? YES NO IF MORE THAN TWO, HOW MANY?

Section 5

Hospital Affiliations

**Admitting
Arrangements**

DO YOU HAVE HOSPITAL PRIVILEGES? YES NO DO YOU HAVE HOSPITAL PRIVILEGES AT MORE THAN ONE HOSPITAL? YES NO

IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5

Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list primary hospital affiliation then secondary or other current affiliation.

PRIMARY HOSPITAL

[Empty box for Hospital Name]

HOSPITAL NAME

[Empty box for Hospital Number]

NUMBER

[Empty box for Hospital Street]

STREET

[Empty box for Hospital Suite/Building]

SUITE/BUILDING

[Empty box for Hospital City]

CITY

[Empty box for Hospital State]

STATE

[Empty box for Hospital Zip Code]

ZIP CODE

[Empty box for Hospital Telephone]

TELEPHONE

[Empty box for Hospital Fax]

FAX

[Empty box for Department Name]

DEPARTMENT NAME

[Empty box for Department Director's Last Name]

DEPARTMENT DIRECTOR'S LAST NAME

[Empty box for Department Director's First Name]

DEPARTMENT DIRECTOR'S FIRST NAME

[Empty box for M.I.]

M.I.

[Empty box for Affiliation Start Date]

AFFILIATION START DATE (MM/YYYY)

[Empty box for Affiliation End Date]

AFFILIATION END DATE (MM/YYYY)

FULL, UNRESTRICTED PRIVILEGES?

[Empty box for Full Privileges Yes]

YES

[Empty box for Full Privileges No]

NO

ARE PRIVILEGES TEMPORARY?

[Empty box for Temp Privileges Yes]

YES

[Empty box for Temp Privileges No]

NO

[Empty box for Admitting Privilege Status]

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?

[Empty box for Annual Admissions Percentage]

%

OTHER HOSPITAL

[Empty box for Hospital Name]

HOSPITAL NAME

[Empty box for Hospital Number]

NUMBER

[Empty box for Hospital Street]

STREET

[Empty box for Hospital Suite/Building]

SUITE/BUILDING

[Empty box for Hospital City]

CITY

[Empty box for Hospital State]

STATE

[Empty box for Hospital Zip Code]

ZIP CODE

[Empty box for Hospital Telephone]

TELEPHONE

[Empty box for Hospital Fax]

FAX

[Empty box for Department Name]

DEPARTMENT NAME

[Empty box for Department Director's Last Name]

DEPARTMENT DIRECTOR'S LAST NAME

[Empty box for Department Director's First Name]

DEPARTMENT DIRECTOR'S FIRST NAME

[Empty box for M.I.]

M.I.

[Empty box for Affiliation Start Date]

AFFILIATION START DATE (MM/YYYY)

[Empty box for Affiliation End Date]

AFFILIATION END DATE (MM/YYYY)

FULL, UNRESTRICTED PRIVILEGES?

[Empty box for Full Privileges Yes]

YES

[Empty box for Full Privileges No]

NO

ARE PRIVILEGES TEMPORARY?

[Empty box for Temp Privileges Yes]

YES

[Empty box for Temp Privileges No]

NO

[Empty box for Admitting Privilege Status]

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?

[Empty box for Annual Admissions Percentage]

%

[Empty box for Terminated Affiliation Explanation]

PLEASE EXPLAIN TERMINATED AFFILIATION

[Empty box for Terminated Affiliation Explanation]

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6

Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION.

CARRIER OR SELF-INSURED NAME* SELF-INSURED?* YES NO

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

ORIGINAL EFFECTIVE DATE* EFFECTIVE DATE* EXPIRATION DATE TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* YES NO \$ \$

AMOUNT OF COVERAGE PER OCCURRENCE AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional Insurance, use the Supplemental Insurance Form on page 21.

CARRIER OR SELF-INSURED NAME SELF-INSURED?* YES NO

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

ORIGINAL EFFECTIVE DATE* EFFECTIVE DATE* (MM/YYYY) EXPIRATION DATE (MM/YYYY) TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* YES NO \$ \$

AMOUNT OF COVERAGE PER OCCURRENCE AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

Section 7

Work History and References

Military Duty

Are you currently on active military duty or military reserve?* YES NO

Work History

Include a chronological work history for the past 10 years, excluding current positions listed in section 4.

A longer period may be required by your dental plan organization.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP/POSTAL CODE

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Work History and References (Continued)

Work History

Do not list current positions. Those should be listed in Section 4.

Include a chronological work history for the past 10 years.

A longer period may be required by your dental plan organization.

<input type="text"/>		<input type="text"/>
TELEPHONE		FAX
<input type="text"/>	<input type="text"/>	<input type="text"/>
COUNTRY CODE	START DATE (MM/YYYY)	END DATE (MM/YYYY)
REASON FOR DEPARTURE (IF APPLICABLE)		
<input type="text"/>		
<input type="text"/>		

WORK HISTORY

<input type="text"/>			
PRACTICE / EMPLOYER NAME			
<input type="text"/>	<input type="text"/>	<input type="text"/>	
NUMBER	STREET	SUITE/BUILDING	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY	STATE	ZIP/POSTAL CODE	
<input type="text"/>	<input type="text"/>		
TELEPHONE	FAX		
<input type="text"/>	<input type="text"/>	<input type="text"/>	
COUNTRY CODE	START DATE (MM/YYYY)	END DATE (MM/YYYY)	
REASON FOR DEPARTURE (IF APPLICABLE)			
<input type="text"/>			
<input type="text"/>			

WORK HISTORY

<input type="text"/>			
PRACTICE / EMPLOYER NAME			
<input type="text"/>	<input type="text"/>	<input type="text"/>	
NUMBER	STREET	SUITE/BUILDING	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY	STATE	ZIP/POSTAL CODE	
<input type="text"/>	<input type="text"/>		
TELEPHONE	FAX		
<input type="text"/>	<input type="text"/>	<input type="text"/>	
COUNTRY CODE	START DATE (MM/YYYY)	END DATE (MM/YYYY)	
REASON FOR DEPARTURE (IF APPLICABLE)			
<input type="text"/>			
<input type="text"/>			

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Work History and References (Continued)

Gaps in Professional / Work History

PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALLED.

GAP START DATE (MM/YYYY)

GAP END DATE (MM/YYYY)

GAP START DATE (MM/YYYY)

GAP END DATE (MM/YYYY)

GAP START DATE (MM/YYYY)

GAP END DATE (MM/YYYY)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7

Work History and References (Continued)

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Code lists are found on pages 24-26. Enter the associated 3-digit code for provider type.

NOTE:

You are required to provide exactly 3 references. Your application will not be complete without this information.

Please check with credentialing entity for any special requirements.

LAST NAME*

FIRST NAME*

PROVIDER TYPE (CODE PG 24)

NUMBER*

STREET*

APT/SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE

FAX

LAST NAME*

FIRST NAME*

PROVIDER TYPE (CODE PG 24)

NUMBER*

STREET*

APT/SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE

FAX

LAST NAME*

FIRST NAME*

PROVIDER TYPE (CODE PG 24)

NUMBER*

STREET*

APT/SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE

FAX

Section 8

Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 22.

1. YES NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*
2. YES NO Has there been any challenge to your licensure, registration or certification?*
3. YES NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
4. YES NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
5. YES NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations including HMOs, dental plans, or provider organizations?*
6. YES NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
7. YES NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
8. YES NO Have any of your board certifications or eligibility ever been revoked, suspended or voluntarily surrendered?*
9. YES NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*
10. YES NO Do you, or your business entity, own, have an investment in, manage, own stock in, participate in a joint venture, or act as a partner, contract consultant or medical/dental advisor in any medical/dental enterprise or medical/dental supplier outside of your direct practice where you would financially benefit directly or indirectly?*
11. YES NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*
12. YES NO Are you currently the subject of an investigation by any hospital, licensing authority, education or training program, Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
13. YES NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
14. YES NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies?*
15. YES NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*
16. YES NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*
17. YES NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
18. YES NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

Section 8

Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 22.

IMPORTANT
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 23 for each malpractice claim.

19. YES NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?*
- If yes, provide information for each case.
20. YES NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*
21. YES NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
22. YES NO Have you ever been court-martialed for actions related to your duties as a medical professional?*
- Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.
23. YES NO Are you currently engaged in the illegal use of drugs?*
- ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice dentistry. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)
24. YES NO Do you use any chemical substances that would in any way impair or limit your ability to practice dentistry and perform the functions of your job with reasonable skill and safety?*
25. YES NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*
26. YES NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, dental groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, dental or health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, credentialing and accreditation agencies, professional dental societies, state dental boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any other material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) 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 Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

DATE SIGNED* (MM/DD/YYYY)

Name (print)*

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1

Practice Location Information - Page 1 of 2

Additional Practice Location

LOCATION* #

CURRENTLY PRACTICING AT THIS ADDRESS?* YES NO PREVIOUS OR FUTURE START DATE?

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

DENTAL GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* YES NO

TELEPHONE*

FAX

OFFICE E-MAIL ADDRESS

 PRIMARY TAX ID (ONE ONLY)* USE INDIVIDUAL TAX ID USE GROUP TAX ID

INDIVIDUAL TAX ID

GROUP TAX ID

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME*

M.I.

TELEPHONE*

FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

LAST NAME*

FIRST NAME*

M.I.

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE*

FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1

Practice Location Information - Page 2 of 2

Add'l Practice Location (Cont.)

LOCATION* #

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

LAST NAME*

M.I.

FIRST NAME*

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	FRIDAY	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>
TUESDAY	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	SATURDAY	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>
WEDNESDAY	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	SUNDAY	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>
THURSDAY	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>					

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?* IF YES
 YES NO ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE VOICE MAIL WITH OTHER INSTRUCTIONS COVERING COLLEAGUE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO ACCEPT ALL NEW PATIENTS?* YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO ACCEPT NEW MEDICAID PATIENTS?* YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* YES NO IF YES, EXPLAIN

CURRENT WAIT TIME FOR INITIAL APPOINTMENT

NUMBER OF OPERATORS AVAILABLE

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Liability Insurance Carrier Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2

Professional Liability Insurance Carrier

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

		SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO
CARRIER OR SELF-INSURED NAME		
NUMBER*	STREET*	SUITE/BUILDING
CITY*	STATE*	ZIP CODE*
ORIGINAL EFFECTIVE DATE* (MM/YYYY)	EFFECTIVE DATE* (MM/YYYY)	EXPIRATION DATE (MM/YYYY)
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ \$
		AMOUNT OF COVERAGE PER OCCURRENCE AMOUNT OF COVERAGE AGGREGATE
POLICY INCLUDES TAIL COVERAGE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
POLICY NUMBER*		

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

		SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO
CARRIER OR SELF-INSURED NAME		
NUMBER*	STREET*	SUITE/BUILDING
CITY*	STATE*	ZIP CODE*
ORIGINAL EFFECTIVE DATE* (MM/YYYY)	EFFECTIVE DATE* (MM/YYYY)	EXPIRATION DATE (MM/YYYY)
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ \$
		AMOUNT OF COVERAGE PER OCCURRENCE AMOUNT OF COVERAGE AGGREGATE
POLICY INCLUDES TAIL COVERAGE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
POLICY NUMBER*		

Disclosure Questions Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3

Disclosure Questions

Disclosure Questions

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. Your response should not exceed the spaces provided.

Record the question number in the first column, then your explanation in the second column.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

QUESTION #	EXPLANATION
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QUESTION #	EXPLANATION
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QUESTION #	EXPLANATION
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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Malpractice Claims Explanation Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4

Malpractice Claims Explanation

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

DATE OF OCCURRENCE* (MM/DD/YYYY)		DATE CLAIM WAS FILED* (MM/DD/YYYY)	
STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN)			
<input type="checkbox"/> OPEN		<input type="checkbox"/> CLOSED	
IF SETTLED, ENTER DATE CLAIM WAS SETTLED (MM/DD/YYYY)			
PROFESSIONAL LIABILITY CARRIER INVOLVED* (USE BOTH LINES IF NECESSARY)			
NUMBER*	STREET*	SUITE/BUILDING	
CITY*		STATE*	ZIP CODE*
TELEPHONE		POLICY NUMBER	
\$		METHOD OF RESOLUTION?*	
		<input type="checkbox"/> DISMISSED <input type="checkbox"/> SETTLED <input type="checkbox"/> MEDIATION <input type="checkbox"/> ARBITRATION	
		<input type="checkbox"/> JUDGMENT FOR DEFENDANT(S) <input type="checkbox"/> JUDGMENT FOR PLAINTIFF(S)	
AMOUNT OF AWARD OR SETTLEMENT*			
DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY)			
WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?*		NUMBER OF OTHER CO-DEFENDANTS (IF ANY)	
<input type="checkbox"/> PRIMARY DEFENDANT <input type="checkbox"/> CO-DEFENDANT		<input type="checkbox"/>	
YOUR INVOLVEMENT IN CASE* (ATTENDING, CONSULTING, ETC)			
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT (USE ALL FOUR LINES BELOW, IF NECESSARY)			
DID THE ALLEGED INJURY RESULT IN DEATH?		TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?*	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Code Lists

Provider Type Codes

001	Medical Doctor (MD)	004	Other
002	Doctor of Dental Surgery (DDS)		
003	Doctor of Dental Medicine (DMD)		

License Status Codes

001	Active	008	Pending	015	Temporary
002	Canceled	009	Probation	016	Terminated
003	Denied	010	Provisional	017	Time Limited
004	Expired	011	Restricted	018	Unrestricted
005	Inactive	012	Revoked	019	Other
006	Lapsed	013	Suspended		
007	Limited	014	Surrendered		

Country Codes

004	Afghanistan	626	East Timor (provisional)	434	Libya	670	Saint Vincent and the Grenadines
008	Albania	218	Ecuador	438	Liechtenstein		
012	Algeria	818	Egypt	440	Lithuania	882	Samoa
016	American Samoa	222	El Salvador	442	Luxembourg	674	San Marino
020	Andorra	226	Equatorial Guinea	446	Macau	678	São Tomé and Príncipe
024	Angola	232	Eritrea	807	Macedonia	682	Saudi Arabia
660	Anguilla	233	Estonia	450	Madagascar	683	Scotland
010	Antarctica	231	Ethiopia	454	Malawi	686	Senegal
028	Antigua and Barbuda	238	Falkland Islands (Malvinas)	458	Malaysia	690	Seychelles
032	Argentina	234	Faroe Islands	462	Maldives	694	Sierra Leone
051	Armenia	242	Fiji	466	Mali	702	Singapore
533	Aruba	246	Finland	470	Malta	703	Slovakia
036	Australia	250	France	584	Marshall Islands	705	Slovenia
040	Austria	249	France, Metropolitan	474	Martinique	090	Solomon Islands
031	Azerbaijan	254	French Guiana	478	Mauritania	706	Somalia
044	Bahamas	258	French Polynesia	480	Mauritius	710	South Africa
048	Bahrain	260	French Southern Territories	175	Mayotte	239	South Georgia and the South Sandwich Islands
050	Bangladesh	266	Gabon	484	Mexico		
052	Barbados	270	Gambia	583	Micronesia	724	Spain
112	Belarus	268	Georgia	498	Moldova	144	Sri Lanka
056	Belgium	276	Germany	492	Monaco	736	Sudan
084	Belize	288	Ghana	496	Mongolia	740	Suriname
204	Benin	292	Gibraltar	500	Montserrat	744	Svalbard and Jan Mayen
060	Bermuda	300	Greece	504	Morocco	748	Swaziland
064	Bhutan	304	Greenland	508	Mozambique	752	Sweden
068	Bolivia	308	Grenada	104	Myanmar	756	Switzerland
070	Bosnia and Herzegovina	312	Guadaloupe	516	Namibia	760	Syria
072	Botswana	316	Guam	520	Nauru	158	Taiwan
074	Bouvet Island	320	Guatemala	524	Nepal	762	Tajikistan
076	Brazil	324	Guinea	528	Netherlands	834	Tanzania
086	British Indian Ocean Territory	624	Guinea-Bissau	530	Netherlands Antilles	764	Thailand
096	Brunei Darussalam	328	Guyana	540	New Caledonia	768	Togo
100	Bulgaria	332	Haiti	554	New Zealand	772	Tokelau
854	Burkina Faso	334	Heard Island and McDonald Islands	558	Nicaragua	776	Tonga
108	Burundi			562	Niger	780	Trinidad and Tobago
116	Cambodia	340	Honduras	566	Nigeria	788	Tunisia
120	Cameroon	344	Hong Kong	570	Niue	792	Turkey
124	Canada	348	Hungary	574	Norfolk Island	795	Turkmenistan
132	Cape Verde	352	Iceland	580	Northern Mariana Islands	796	Turks and Caicos Islands
136	Cayman Islands	356	India	578	Norway	798	Tuvalu
140	Central African Republic	360	Indonesia	512	Oman	800	Uganda
148	Chad	364	Iran	586	Pakistan	804	Ukraine
152	Chile	368	Iraq	585	Palau	784	United Arab Emirates
156	China	372	Ireland	591	Panama	826	United Kingdom
162	Christmas Island	376	Israel	598	Papua New Guinea	840	United States
166	Cocos (Keeling) Islands	380	Italy	600	Paraguay	581	U.S. Minor Outlying Islands
170	Colombia	388	Jamaica	604	Peru	858	Uruguay
174	Comoros	392	Japan	608	Philippines	860	Uzbekistan
178	Congo	400	Jordan	612	Pitcairn	548	Vanuatu
180	Congo, Democratic Republic of the	398	Kazakhstan	616	Poland	336	Vatican City State (Holy See)
184	Cook Islands	404	Kenya	620	Portugal	862	Venezuela
188	Costa Rica	296	Kiribati	630	Puerto Rico	704	Viet Nam
384	Cote d'Ivoire	408	Korea, North	634	Qatar	092	Virgin Islands, British
191	Croatia	410	Korea, South	638	Réunion	850	Virgin Islands, U.S.
192	Cuba	414	Kuwait	642	Romania	876	Wallis and Fortuna Islands
196	Cyprus	417	Kyrgyzstan	643	Russian Federation	732	Western Sahara (provisional)
203	Czech Republic	418	Laos	646	Rwanda	887	Yemen
208	Denmark	428	Latvia	654	Saint Helena	891	Yugoslavia
262	Djibouti	422	Lebanon	659	Saint Kitts and Nevis	894	Zambia
212	Dominica	426	Lesotho	662	Saint Lucia	716	Zimbabwe
214	Dominican Republic	430	Liberia	666	Saint Pierre and Miquelon		

Code Lists

Language Codes

001	Abkhazian	036	Frisian	071	Macedonian	106	Slovak
002	Afan (Oromo)	037	Galician	072	Malagasy	107	Slovenian
003	Afar	038	Georgian	073	Malay	108	Somali
004	Afrikaans	039	German	074	Malayalam	109	Spanish
005	Albanian	040	Greek	075	Maltese	110	Sundanese
006	Amharic	041	Greenlandic	076	Maori	111	Swahili
007	Arabic	042	Guarani	077	Marathi	112	Swedish
008	Armenian	043	Gujarati	078	Moldavian	113	Tagalog
009	Assamese	044	Hausa	079	Mongolian	114	Tajik
010	Zerbaijani	045	Hebrew	080	Nauru	115	Tamil
011	Bashkir	046	Hindi	081	Nepali	116	Tatar
012	Basque	047	Hungarian	082	Norwegian	117	Telugu
013	Bengali; Bangla	048	Icelandic	083	Occitan	118	Thai
014	Bhutani	049	Indonesian	084	Oriya	119	Tibetan
015	Bihari	050	Interlingua	085	Pashto; Pushto	120	Tigrinya
016	Bislama	051	Interlingue	086	Persian (Farsi)	121	Tonga
017	Breton	052	Inuktitut	087	Polish	122	Tsonga
018	Bulgarian	053	Inupiak	088	Portuguese	123	Turkish
019	Burmese	054	Irish	089	Punjabi	124	Turkmen
020	Byelorussian	055	Italian	090	Quechua	125	Twi
021	Cambodian	056	Japanese	091	Rhaeto-Romance	126	Uigur
022	Catalan	057	Javanese	092	Romanian	127	Ukrainian
023	Chinese	058	Kannada	093	Russian	128	Urdu
024	Corsican	059	Kashmiri	094	Samoan	129	Uzbek
025	Croatian	060	Kazakh	095	Sangho	130	Vietnamese
026	Czech	061	Kinyarwanda	096	Sanskrit	131	Volapuk
027	Danish	062	Kirghiz	097	Scot Gaelic	132	Welsh
028	Dutch	063	Kurundi	098	Serbian	133	Wolof
140	English	064	Korean	099	Serbo-Croatian	134	Xhosa
030	Esperanto	065	Kurdish	100	Sesotho	135	Yiddish
031	Estonian	066	Laothian	101	Setswana	136	Yoruba
032	Faroese	067	Latin	102	Shona	10	Zerbaijani
033	Fiji	068	Latvian; Lettish	103	Sindhi	137	Zhuang
034	Finnish	069	Lingala	104	Singhalese	138	Zulu
035	French	070	Lithuanian	105	Siswati		

U.S. / Canadian Professional School Codes

Alabama

300 University of Alabama School of Dentistry

Arizona

900 Arizona School of Dentistry and Oral Health

California

301 Loma Linda University School of Dentistry
 302 University of California, Los Angeles School of Dentistry
 303 University of California, San Francisco, School of Dentistry
 304 University of Southern California School of Dentistry
 305 University of the Pacific School of Dentistry

Colorado

306 University of Colorado School of Dentistry

Connecticut

307 University of Connecticut School of Dental Medicine

District of Columbia

308 Howard University College of Dentistry

Florida

309 Nova Southeastern University College of Dentistry
 310 University of Florida College of Dentistry

Georgia

311 Medical College of Georgia School of Dentistry

Iowa

312 University of Iowa College of Dentistry

Illinois

313 Northwestern University Dental School
 314 Southern Illinois University School of Dental Medicine
 315 University of Illinois at Chicago College of Dentistry

Indiana

316 Indiana University School of Dentistry

Kentucky

317 University of Kentucky College of Dentistry
 318 University of Louisville School of Dentistry

Louisiana

319 Louisiana State University School of Dentistry

Massachusetts

320 Boston University, Goldman School of Dental Medicine
 321 Harvard School of Dental Medicine
 322 Tufts University School of Dental Medicine

Maryland

323 University of Maryland, Baltimore, College of Dental Surgery

Michigan

324 University of Detroit Mercy School of Dentistry
 325 University of Michigan School of Dentistry

Minnesota

326 University of Minnesota School of Dentistry

Missouri

327 University of Missouri Kansas City School of Dentistry

Mississippi

328 University of Mississippi School of Dentistry

North Carolina

329 University of North Carolina at Chapel Hill School of Dentistry

Nebraska

330 Creighton University School of Dentistry
 331 University of Nebraska Medical Center, College of Dentistry

Code Lists

U.S. / Canadian Professional School Codes (continued)

Nevada

901 University of Nevada Las Vegas School of Dental Medicine

New Jersey

332 UMDNJ, New Jersey Dental School

New York

333 Columbia University School of Dental and Oral Surgery
 334 New York University Kriser Dental Center
 335 State University of New York at Buffalo School of Dental Medicine
 336 State University of New York at Stony Brook School of Dental Medicine

Ohio

337 Case Western Reserve University School of Dentistry
 338 Ohio State University College of Dentistry

Oklahoma

339 University of Oklahoma College of Dentistry

Oregon

340 Oregon Health Sciences University School of Dentistry

Pennsylvania

341 Temple University School of Dentistry
 342 University of Pennsylvania School of Dental Medicine
 343 University of Pittsburgh School of Dental Medicine

Puerto Rico

344 University of Puerto Rico School of Dentistry

Rhode Island

South Carolina

345 Medical University of South Carolina College of Dental Medicine

South Dakota

Tennessee

346 Meharry Medical College School of Dentistry
 347 University of Tennessee College of Dentistry

Texas

348 Baylor College of Dentistry
 349 University of Texas Health Science Center at Houston Dental School
 350 University of Texas Health Science Center at San Antonio Dental School

Virginia

351 Virginia Commonwealth University School of Dentistry

Washington

352 University of Washington School of Dentistry

Wisconsin

353 Marquette University School of Dentistry

West Virginia

354 West Virginia University School of Dentistry

Canada

355 Dalhousie University Faculty of Dentistry
 357 Laval University Faculty of Dentistry
 356 McGill University Faculty of Dentistry
 132 The University of Western Ontario Faculty of Medicine & Dentistry
 358 University of Alberta Faculty of Dentistry
 359 University of British Columbia Faculty of Dentistry
 360 University of Manitoba Faculty of Dentistry
 138 University of Manitoba Faculty of Medicine
 361 University of Montreal Faculty of Dentistry
 362 University of Saskatchewan College of Dentistry
 363 University of Toronto Faculty of Dentistry
 364 University of Western Ontario Faculty of Dentistry

Other

999

Specialty Codes - DDS / DMD

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

DDS / DMD	16 Dentist, Oral and Maxillofacial Pathology	18 Dentist, Periodontics
2 Dentist	439 Dentist, Oral and Maxillofacial Radiology	19 Dentist, Prosthodontics
13 Dentist, Dental Public Health	20 Dentist, Oral and Maxillofacial Surgery	99 Other
14 Dentist, Endodontics	15 Dentist, Orthodontics and Dentofacial Orthopedics	
438 Dentist, General Practice	17 Dentist, Pediatric Dentistry	

Specialty Boards - Dental

113 American Board of Endodontics	112 American Board of Pediatric Dentistry
114 American Board of Oral & Maxillofacial Pathology	111 American Board of Periodontology
117 American Board of Oral & Maxillofacial Radiology	115 American Board of Prosthodontics
109 American Board of Oral & Maxillofacial Surgeons	106 American Board of Public Health Dentistry
108 American Board of Orthodontics	120 Boards other than ABMS/AOA