Dental Provider Application

OXFORD HEALTH PLANS®

A UnitedHealthcare Company

8086 R1

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Dental Application Instructions

To apply for participation, please fill out the enclosed application, completing all appropriate sections and providing all required materials. Please mark the check boxes to indicate that you have included the required material, sign this form, and return it with your application in the enclosed envelope.

You are required to return the following materials in the enclosed envelope:

- ❒ Completed application form
- ❒ Current copy of DEA certificate
- ❒ Current copy of CDS (New Jersey applicants only)
- ❒ Current copy of state license
- ❒ Copy of Board Certificates for Specialty (if applicable)
- ❒ Signed copy of the Oxford Primary Care Dentist Agreement or Specialty Care Dentist Agreement
- ❒ All information/records of continuing dental education for the last three years
- ❒ Current copy of Malpractice Insurance declaration page (evidencing coverage of at least $1,000,000 per claim and $3,000,000 coverage in the aggregate)
- ❒ Completed W-9 Form for all locations if different Tax ID is used at each location

Note: Applications that are incomplete in any way and applications submitted without proof of all of the necessary credentials will experience a delay in processing, and may be returned to you for completion.

Please be sure to include all information requested above, then sign and mail your completed application, using the enclosed envelope. If you have any questions, please call 1-800-520-1829, and select option 3. Thank you in advance for your cooperation.

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Dental Application

I. GENERAL INFORMATION — PLEASE PRINT

Provider Name: _____
Last First MI

Sex: ❑ Male ❑ Female

Type of Practice: ❑ Solo ❑ Group ❑ Multi-Specialty Group ❑ Other

Date of Birth_____ Place of Birth _____

Social Security Number _____ Degree _____

DEA Number _____Exp. Date _____

CDS Number (NJ only) _____ Exp. Date _____

License: State _____ License Number _____ Exp. Date _____

Are you licensed to practice in any other state(s)? ❑ Yes ❑ No If yes, please list.

State _____ License Number _____ Exp. Date _____

State _____ License Number _____ Exp. Date _____

Applying as: ❑ Primary Care Dentist
❑ Specialty Dentist Practicing Specialty(ies): _____

Years in practice? _____

Languages spoken (other than English): _____

Group affiliations (Please list any other Dental Managed Care Organizations you are affiliated with):

_____

_____

Have you ever been refused participation in the network of a managed care organization (HMO or PPO) or been disciplined by or terminated from such a plan or organization? ❑ Yes ❑ No If yes, please explain.

_____

_____

II. PRIMARY PRACTICE INFORMATION

Important: Please disclose all Federal Taxpayer Identification Numbers (FTIN) and all locations where you practice. Failure to do so may result in denied claims.

Legal Name of Practice

DBA (trade name)

Street | Suite | Tax ID # (attach a W-9)

City | State | Zip Code + 4 | County

Office Manager's Name | Office Phone Number | 24-Hr. Coverage | Fax Number

Billing address (if different from address listed above) _____

Times you are available in the office: (Not hours office is in operation)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

1. Are the patient areas of the office accessible to people in wheelchairs or with other mobility impairments? ❑ Yes ❑ No

2. Does the office provide signs or other communication systems (raised symbol and lettering) for people who are blind or have vision impairments?
❑ Yes ❑ No

3. Age range of patients you will see: _____

4. Type of 24-hour emergency coverage you have: ❑ Answering machine ❑ Answering machine with alternate number
❑ Answering Service ❑ Answering Service with alternate number; Alternate number is a __ Pager Number __ Home Telephone Number
❑ Other (please describe)_____

5. Is your office computerized? ❑ Yes ❑ No If yes, do you submit claims electronically? ❑ Yes ❑ No

6. Number of operatories: _____ Number of chair-side assistants: _____

7. Do you have a dental hygienist on staff? ❑ Yes ❑ No ❑ Full-Time ❑ Part-Time # of days _____

8. Do you have Internet access? ❑ Yes ❑ No If yes, what is your e-mail address? _____

Description of practice:

General practitioners may provide any information that will be helpful to patients in their selection of a primary care dentist. Specialists may indicate areas of expertise that will be helpful when making referrals.

_____

_____

III. ADDITIONAL PRACTICE

(If you have additional practice locations, please make a photocopy this page for each location and add it to the application).

Legal Name of Practice

DBA (trade name)

Street | Suite | Tax ID # (attach a W-9)

City | State | Zip Code + 4 | County

Office Manager's Name | Office Phone Number | 24-Hr. Coverage | Fax Number

Billing address (if different from address listed above) _____

Times you are available in the office: (Not hours office is in operation)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

1. Are the patient areas of the office accessible to people in wheelchairs or with other mobility impairments? ❑ Yes ❑ No

2. Does the office provide signs or other communication systems (raised symbol and lettering) for people who are blind or have vision impairments?
❑ Yes ❑ No

3. Age range of patients you will see: _____

4. Type of 24-hour emergency coverage you have: ❑ Answering machine ❑ Answering machine with alternate number
❑ Answering Service ❑ Answering Service with alternate number; Alternate number is a __ Beeper Number __ Home Telephone Number
❑ Other (please describe)_____

5. Is your office computerized? ❑ Yes ❑ No If yes, do you submit claims electronically? ❑ Yes ❑ No

6. Number of operatories: _____ Number of chair-side assistants: _____

7. Do you have a dental hygienist on staff? ❑ Yes ❑ No ❑ Full-Time ❑ Part-Time No. of days _____

8. Do you have Internet access? ❑ Yes ❑ No If yes, what is your e-mail address? _____

Description of practice:

General Practitioners may provide any information that will be helpful to patients in their selection of a primary care dentist. Specialists may indicate areas of expertise that will be helpful when in making referrals.

_____

_____

IV. EDUCATION

	Institution	State/Country	Degree	Graduation Date
Undergraduate				
Dental School				
Specialty Training				

V. POST-GRADUATE TRAINING

	Program/Hospital	Specialty	State/Country	Dates
Residency				
Other				

Are you board-certified? ❑ Yes ❑ No If yes, American Board of _____

Are you board-eligible? ❑ Yes ❑ No If yes, when do you plan to take the boards?_____

Has your eligibility expired? ❑ Yes ❑ No Expiration date _____

Please provide proof of Board status from the applicable Board

VI. PROFESSIONAL STATUS

Please read and INITIAL statements 1-7 below, to signify that you affirm the statements.

- **If you cannot affirm statement number "1" below, please provide the following information for each claim or suit on a separate sheet:**

  A) year and month of occurrence; B) nature of allegation; C) whether or not the suit has been filed;

  D) current status of the claim or suit; E) the disposition of the suit (did plaintiff or defendant prevail);

  F) amount of any payment; G) whether payment was a settlement or an award; and H) a narrative description of the facts.

- **If you cannot affirm any of statements 2 through 7 below, please submit a full explanation on a separate sheet.**

_____ 1. I do not now have, nor have I had in the past five (5) years, any malpractice claims, malpractice settlements or criminal actions brought against me.

_____ 2. There are no professional dental misconduct proceedings or peer review-type proceedings pending wherein I am a party, in this state or any other state or country.

_____3. There have been no judgments, settlements, findings, decisions, or other determinations of any kind whatsoever entered or made in any professional dental misconduct proceedings or peer review-type proceedings wherein I was a party, in this state or any other state or country in the past five (5) years.

_____ 4. My license to practice dentistry in any state or country has never been suspended, revoked, or subject to limitations or voluntary relinquishment.

_____ 5. I am not currently under investigation nor have any charges been brought against me by any hospital or other healthcare institution, third-party payer, Medicare or Medicaid, or governmental licensing or other authority.

_____ 6. I do not have any physical or mental health conditions, including alcohol or substance abuse, that would interfere with my ability to perform my duties as a dentist.

_____ 7. My license to prescribe narcotics has never been voluntarily relinquished nor involuntarily refused, suspended or revoked.

I hereby affirm and represent that all statements, answers and information contained in this application are correct and complete. I understand that any misrepresentation or omission of any fact requested in this application may result in termination from Oxford's dental network. I hereby agree to notify Oxford immediately if such representations ever cease to be accurate and true.

I understand and agree that my completion of this application does not guarantee or constitute participation in Oxford, and it grants me no rights or privileges until such time as my application is formally approved. Upon receipt of said formal notice of approval, I hereby agree to provide dental care to Members in accordance with all the terms of the applicable Oxford Health Plans Primary Care/Specialist Dentist Agreement, a copy of which I have received and read, as the same may be amended from time to time in accordance with the terms thereof.

I understand and agree that a credential review process will occur prior to the approval of my participation. I hereby authorize any person, institution or party who may have information or documentation, including otherwise privileged or confidential information or documentation, pertaining to my professional qualifications, quality of care, utilization of medical services, or professional standards or ethics concerning my practice, to provide such information or documentation to. I understand and agree that all recommendations and disclosures of records of information will be privileged to the fullest extent permitted by law. I further agree not to bring any administrative proceeding or take any judicial action against Oxford or any person or institution providing, receiving or using any such material.

I hereby release any person, institution or other party from any liability in connection with the provision of such information or documentation.

Signature: _____ **Date:** _____

Oxford acknowledges that it will maintain the confidentiality of this application and all information and documentation relating to this application.

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W-9 Substitution Form

SUBJECT: REQUEST FOR FEDERAL TAXPAYER IDENTIFICATION NUMBER (FTIN)

PART I: Provide EITHER a Social Security Number

OR
an Employer Identification number (EIN).

PART II: Classify your status for IRS reporting.

PART III: Provide us with the name that the IRS has on file for you or your business. Please note that the IRS must be able to match the information you provide to us with their files. Therefore, we require the exact legal name of your company or organization. Please list all subsidiaries that share this Employer Identification Number. You are required to provide us with a remittance address to ensure that checks are sent to the correct location.

Please provide the W-9 information requested on the reverse of this page, and return this form to Oxford Health Plans with your application materials.

- **If you are an associate within a group practice, please provide the FTIN # as it relates to the group name or practice owner.**
- **If you are submitting an application for an associate, please provide the FTIN # your associate will be using as a member of your practice.**
- **The address on your W-9 must match the billing address on your application.**

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Taxpayer Identification Number and Certification Request

PART I

Federal Income Tax Law & Regulations require that you provide us with your Federal Taxpayer Identification Number (FTIN). If you are an individual or sole proprietorship, your FTIN is usually your Social Security number (SSN). If you are a corporation or partnership, your FTIN is your Employer Identification Number (EIN). Please do not provide us with both numbers.

SOCIAL SECURITY NUMBER (SSN) _____

EMPLOYER IDENTIFICATION NUMBER (EIN) _____

EFFECTIVE DATE OF TAX ID _____

PART II

Please check the category that applies to you or your corporation:

Individual	_____	**Partnership, Professional Association (PA), or Professional Corporation (PC)**	_____
Corporation	_____	**501 (a,c) Exempt Organization**	_____
Foreign Entity	_____	**Government Organization**	_____

PART III

If you are an individual or sole proprietorship, provide the exact name as shown on your Social Security card:

_____

If you are a corporation, partnership, PA, PC, or organization, please provide us with the business name (exact legal name):

_____

Remittance Address (street, city, state, Zip code):

_____

_____

Subsidiary Companies or DBAs (sharing your EIN):

_____

IF APPROPRIATE, PLEASE ATTACH A LIST OF ALL INDIVIDUALS USING THE CORPORATE FTIN FOR BILLING PURPOSES.

I certify, under penalties of perjury, that the information above is correct.

Signed by:_____ Date _____

Print name: _____ Telephone number: _____

For Internal Use Only:

Assigned Oxford Provider ID # _____

Please forward this form to: Vendor Audit Department, 48 Monroe Turnpike, Trumbull, CT 06611 Fax: 1-866-561-3966