DELTA DENTAL OF ARKANSAS
RE-CREDENTIALING APPLICATION
DELTA PREMIER
PREFERRED PROVIDER OPTION
DELTA USA

Name: _____ TIN / SSN: _____

Practice Name: _____

Primary Office Address:_____

City: _____ State: _____ Zip Code: _____

Office Phone Number: ( )_____ Fax Number: ( )_____

E-Mail Address: _____

Billing/Payment mailing address: _____

Additional Office Locations, if applicable:

Practice Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone Number: _(____)_____

Type 1 NPI _____ Type II NPI _____

1. Does your office follow the current recommendations of the American Dental Association and the Center for Disease Control regarding infection control? ____Yes ____No. If no, explain
   _____
2. Do you comply with Occupational Exposure to Blood borne Pathogens Standards of the OSHA Regulations? ____ Yes ____No. If no, explain_____

   _____
3. Is oxygen available in your office? ____Yes ____ No
4. Do you have a protocol in place to handle medical emergencies? ____Yes ____ No
5. Within the last five (5) years, have any of these situations applied to you?
   a. Have you been involved in a malpractice suit or claim? ____ Yes ____ No

   b. Has your license to practice dentistry in any state been revoked, suspended, placed on probation, or voluntarily relinquished? ____Yes ____ No

c. Has disciplinary action of any sort, been taken against you by an ethics Committee, licensing board, or professional association? ____Yes ____No

d. Have you been subject to sanctions by Medicare, Medicaid, or any other state or federal program? ____Yes ____ No

e. Have you been reported to the National Practitioner Data Bank? ____Yes ____No

f. Has your Drug Enforcement Agency (DEA) license been revoked, suspended, or placed on probation? ____Yes ____No

g. Within the past five years, have you had any substance abuse problems that would impair your ability to practice dentistry? ____Yes ____No

If you answered YES to any part of question 5, please attach a letter of explanation.

Enclose a copy of your current professional liability (malpractice) certificate declaration page

I certify that the information contained herein, including all supporting materials, is true and complete to the best of my knowledge and belief. I understand that my application will be reviewed based upon the information I have provided and other information obtained by Delta Dental of Arkansas (DDAR) in accordance with its credentialing program. I further understand that information which is found to be false could result in the termination of my DDAR participating agreement.

I authorize the Arkansas State Board of Dental Examiners (or other dental licensing agencies in any state in which I am licensed to practice dentistry), and any health care facility, health maintenance organization or professional organization with whom I have had employment, practice, association or privileges, to release information to DDAR regarding any pending or final disciplinary or malpractice action.

I release from liability a) any person or entity that, in good faith and without malice, provides information to DDAR for the purpose of evaluating my application; and b) DDAR for their acts performing in good faith and without malice in connection with evaluating my application.

Please return to:
Delta Dental of Arkansas, Inc.
Professional Relations
PO Box 15965
North Little Rock, AR 72231-5965
Fax: (501) 992-1867

_____
Applicant-Signature Date

_____
Please Print Name and License Number