CREDENTIALING APPLICATION

Fax: (714) 571-3650
Email: Provider_Relations@westerndental.com

Current Professional Liability Insurance Certificate must be enclosed.

1. PERSONAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____/_____/_____ Office Phone: _____ Office Fax: _____

NPI Number (Individual): _____ Dental License Number: _____ License State: _____

If applicable:

DEA License Number: _____ State: _____ Social Security Number:

2. CREDENTIALS

Board Certified ☐YES ☐ NO Board Name: _____ Certification Date: _____/_____/_____

Hospital Affiliations ☐YES ☐ NO Hospital Name: _____ Hospital City: _____

In the last three years has there been any changes to your highest level of specialty, license or education in any State? ☐ Yes ☐ No

3. PROFESSIONAL QUESTIONNAIRE

You MUST supply a written explanation with dates and settlement amounts for any "yes" responses.

☐YES ☐NO Have you ever been or are you currently involved in any malpractice (or any other civil) claims/lawsuits, settlements or judgments? If yes, please provide detailed information on a separate piece of paper including: docket number of the case, location of the court, the names of the parties, plaintiff(s) and defendant(s), description of the incident(s), date(s) of the incident(s), your involvement, and the current disposition.

☐YES ☐NO Has your license to practice, either in any jurisdiction, whether completed or still pending, been denied, restricted, limited, suspended, revoked, not renewed or have you ever been placed under probation, subjected to disciplinary action or otherwise sanctioned, limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions?

☐YES ☐NO Has your professional liability insurance ever been denied, suspended, revoked, canceled, or not renewed?

☐YES ☐NO Has your Federal and/or State DEA Registration Certificate ever been denied, suspended, canceled or not renewed, or subject to any disciplinary action

☐YES ☐NO Are your privileges or memberships at any hospital, institution (military service) and/or HMO currently under investigation or have they ever been denied, suspended, reduced, or not renewed; or have any other disciplinary proceedings ever been instituted against you?

☐YES ☐NO Have you ever been denied membership, or renewal thereof, or been subject to disciplinary proceedings for a dental (medical) or ethical reason by any dental/ professional organization?

☐YES ☐NO Has your status as a provider ever been denied, suspended, canceled, sanctioned or has any disciplinary action ever been taken against you, or are you currently under investigation by any municipal, state, federal or any other governmental agency as well as, DHMO, PPO or other prepaid health plan? (e.g. Medicare, Medi-Cal, Medicaid).

☐YES ☐NO Do you have any physical or mental impairment that would impede your ability, with or without reasonable accommodation, to carry out the scope of your professional duties on behalf of Western Dental Services, Inc.?

☐YES ☐NO Do you have or have been subject to any chronic illness, physical defects, substance abuse or any other issues which would (with or without reasonable accommodation required by the American With Disabilities Act): (a) pose a direct threat to patients, or (b) render you unable to perform any procedures within the scope of privileges and duties as a dental health care provider or within accepted standards of professional performance?

☐YES ☐NO Do you have any felony or misdemeanor charges pending against you, other than a traffic violation, or have you ever been convicted of a felony, or pleaded "nolo contendere" to a felony? (Note: Conviction(s) will not necessarily disqualify an applicant from employment.)

☐YES ☐NO Do you have any physical or mental impairment due to chemical dependency/substance abuse?

☐YES ☐NO Have you ever been terminated from employment or arrested for committing a sexual offense?

☐YES ☐NO Have you ever been denied membership, or renewal thereof, or been subject to disciplinary proceedings for a dental (medical) or ethical reason by any dental/ professional organization?

4. ATTESTATION ACKNOWLEDGEMENTS / INFORMATION RELEASE AUTHORIZATION

In completing and signing this attestation, I:

- Attest that all information provided within this application is current, true, and accurate to the best of my knowledge and furnished in good faith;
- Agree to provide and maintain liability insurance at time of submission of this application;
- Release and hold harmless Western Dental Plan and any of its respective officers, directors, representatives, employees, agents and affiliated entities from any and all liability for any damages, costs and expenses which may result from the gathering or use of the information gathered during the credentialing process providing such release of information is done in good faith and without malice.
- Give consent to Western Dental Plan to request information regarding professional credentials and qualifications including but not limited to the information contained within my application;
- Understand that I have the right to obtain the status and to review and correct erroneous information obtained by Western Dental Plan to evaluate my credentialing application at any time after submitting my application.
- Understand that this application does not entitle me to participation in Western Dental Plan's Network.
- Agree that neither Western Dental Plan nor its representatives or any individuals or entities providing information to Western Dental in good faith shall be liable for any act or omission related to the evaluation or verification of the information contained in this application.
- Acknowledge that information requested in this application that is not publicly available will be treated as confidential by Western Dental Plan.

My signature below authorizes and attests that all information Western Dental has on file and/or changes I have made to complete and correct this application are true, correct, and complete. I authorize Western Dental Plan to collect any information necessary to verify the information in this credentialing application, including from third party sources.

Signature: _____ **Print Name:** _____

Date: _____/_____/_____ *Print Full Name as indicated on CA Dental License including Middle Name, if applicable*