DELTA DENTAL

Service Office Location Change Form

Fax Number: 973-285-4192

Please indicate the effective date of the change _____/_____/_____ ***Required***
(Claims submitted from the new location with dates of service prior to the effective date or in the absence of may reflect non participating status. Please confirm date.)

Dentist Name: _____ Dentist License #: _____

(Each dentist must fill out his/her own change form. Copies are accepted.)

☐This change of address applies only to me.
(I am the only dentist at this location.)

☐ This change applies to multiple dentists. (A form is required for each dentist, separately.)

Applicable Program(s) I wish to continue my participation: Check (✓) all programs that apply:

☐ Delta Dental Premier ☐ Delta Dental PPO ☐ Advantage Program (NJ only)
☐ Non-Participating ☐ Delta Dental Patient Direct (NJ only)

OLD ADDRESS: _____

NEW ADDRESS: _____
(Physical office location of treatment.)

Phone #: _____ Fax #: _____

Email address: _____

NEW BILLING LOCATION: _____
(Where checks are to be mailed.)

Name for IRS Form 1099 Reporting: _____
(Must be identical to how it appears on IRS Form W-9.)

Tax Identification Number for IRS Form 1099 Reporting: _____

I attest that the information provided in my most recent Credentialing on file at the "old office address" remains correct. I further attest all Participation Agreements, Participating Dentist Rules & Regulations in effect at the "old" address will remain in full effect at the "new" address, included my usual fees on file with Delta Dental.

_____ _____
Applicant - Print Name Owner - Print Name

_____ _____
Applicant Signature Owner - Signature

Delta Dental Administrative Use Only:

PR Auth.(initial/date) _____ Par Status: _____If DDLP: TN _____

Cred Assoc _____ Last Credentialed: _____

PS 02/17

DELTA DENTAL

Attn: OS
Change of Address or Tax ID

DELTA DENTAL OF NEW JERSEY, INC.
DELTA DENTAL OF CONNECTICUT, INC.

INITIAL DENTIST CREDENTIALING APPLICATION (SERVICE OFFICE SURVEY)

Please complete all requested information for this service office and return it to Delta Dental of New Jersey. **Please note, we cannot process your application until all required information is received, which may affect your participation status.**

Refer to the enclosed Connecticut and New Jersey Credentialing Criteria for information relating to the questions asked in the survey. Delta Dental acknowledges that it will, except as required by law, maintain the confidentiality of this application and documentation relating to this application.

I. SERVICE OFFICE INFORMATION

_____
Office/Practice Name (must be identical to how it appears on IRS Form W-9)

_____
Address: Street City State Zip

Phone: (_____)_____ Fax: (_____)_____

Email:_____ Website: _____

Tax Identification #: _____ Corporate NPI #: _____

Owner's Name: _____ Owner's License #: _____

Type of Practice (Please (✓) check): ❒Solo ❒Group ❒Partnership ❒Corporate Entity (LLC/PC)

Indicate whom Delta Dental should contact should we have questions on this form:

Name: _____ Title: _____

II. SERVICE OFFICE SURVEY

This section is to be completed by the owner of the practice. Reminder: Owner responding in the affirmative to the questions asked in the service office survey agree to meet the criteria contained in the Credentialing Criteria.

1. INFECTION CONTROL	**YES**	**NO**	**If "NO", please explain:**
A. Does your office comply with local, state, and federal, ADA and CDC guidelines pertaining to infection control?	____	____	_____
2. RADIATION HYGIENE	**YES**	**NO**	**If "NO", please explain:**
A. Are you compliant with all applicable legal requirements including current valid permits or filings?	____	____	_____
B. Do radiographic techniques meet accepted professional standards?	____	____	_____
C. Are radiographs prescribed in accordance with accepted professional standards?	____	____	_____
3. EMERGENCY PREPAREDNESS	**YES**	**NO**	**If "NO", please explain:**
A. Are medical alerts current, accurate, and indicated on the patient's chart in such a manner as to alert the dentist and office staff as well as protect the patient's privacy?	____	____	_____
B. CPR training and availability			
1. Are you and/or your staff members trained in CPR?	____	____	_____
2. Is someone who is trained in the management of emergencies (including current CPR training) always present when there are patients present in the office?	____	____	_____
C. Do you have protocol in place to handle medical emergencies?	____	____	_____
D. Is portable oxygen equipment readily available and are staff trained in its use?	____	____	_____
E. Do you operate your practice in compliance with all applicable legal requirements?	____	____	_____
F. Are practice drills on handling emergencies conducted?	____	____	_____
G. Are all new staff members trained on office emergency protocols?	____	____	_____
H. Do you have accessible and up to date Medical Emergency Drug Kit?	____	____	_____

4. RECORD KEEPING	YES	NO	If "NO", please explain:
A. Does your office take an initial medical/dental history with periodic updates?	____	____	_____
B. Are patient records written in ink or computerized and kept in compliance with all legal requirements applicable to your practice?	____	____	_____
C. Is the treating dentist or hygienist noted in the dental record?	____	____	_____
D. Does the patient record include the following?			
1. Treatment Plan Presentation	____	____	_____
2. Dates of Service	____	____	_____
3. Services Rendered	____	____	_____
4. Clinical Findings/Diagnosis	____	____	_____
5. Diagnostic Tests Rendered and Results	____	____	_____
6. Progress Notes	____	____	_____
7. Outcomes	____	____	_____
8. Post Operative Instructions are recorded	____	____	_____
9. Documentation of prescriptions given or prescribed	____	____	_____
10. Laboratory work order forms	____	____	_____
11. Written informed consent/informed refusal	____	____	_____
E. Are financial records and arrangements accessible and if computerized do they meet regulatory requirements?	____	____	_____

5. APPOINTMENT AND ACCESS FOR DELTA DENTAL PATIENTS

Free parking available?	*Yes*___ *No*___
Access to public transportation?	*Yes*___ *No*___
Comply with the access and reasonable accommodation provisions of the Americans with Disabilities Act?	*Yes*___ *No*___
Treat children with disabilities?	*Yes*___ *No*___
Treat adults with disabilities?	*Yes*___ *No*___
Currently accepting new patients into your practice?	*Yes*___ *No*___
Delta Dental patients given access to appointments within 21 days or less?	*Yes*___ *No*___
Delta Dental patients given the same level of care and access to appointments as private (non-insured) patients?	*Yes*___ *No*___
Immediate access to emergency care? (Immediate access is provided when the office is able to directly or through arrangements with another office respond to the patient's emergency condition within the length of time necessary to effectively handle the condition.)	*Yes*___ *No*___

Standard Business Hours:

From: _____ To: _____

Days of Operation:

Mon ❒ Tue ❒ Wed ❒ Thu ❒ Fri ❒ Sat ❒ Sun ❒

Extended Business Hours:

Standard business hours (8 am-5 pm): ❒
Early morning hours (before 8:00 am): ❒
Evening hours (after 5:00 pm): ❒
Weekend hours (Saturday hours): ❒

List all languages spoken in the office other than English:

_____

_____

_____

Please provide an explanation for any statement above to which you responded "No":

_____

_____

_____

_____

_____

_____

6. SUPPORT STAFF

A. Do you warrant that all individuals treating patients in your practice are duly licensed? *Yes* ___ *No*___

B. Do you warrant that all dentists treating patients in your practice maintains a minimal malpractice limits of $1,000,000 per claim and $3,000,000 aggregate?

Yes ___ *No*___

C. Do you warrant that to the best of your knowledge any person who renders patient care in your office is without any physical, psychological, clinical dependency or abuse or any other health related conditions which may impair their ability to safely and competently practice dentistry and/or surgery or which may endanger your patients?

Yes ___ *No*___

If your answer is "No" to any of the above questions, please attach a written explanation.

7. GOVERNMENTAL PROGRAM STATUS

Please answer the following question. If you answer "yes", please attach a written explanation and copies of all notices or decisions relating to the ***government*** *action and the current status.*

Has any individual treating patients in your practice ever been suspended, debarred, or excluded from participating as a provider in any governmental program, including, but not limited to Medicare, Medicaid, or any other program funded in whole or in part by the federal government or a state or local government?

Yes ___ *No*___

III. CERTIFICATION

In submitting this application for Credentialing (or recredentialing) by Delta Dental of New Jersey, Inc. ("Delta Dental"), I understand that it is my responsibility to produce the required information for the proper evaluation of my application and that failure to produce this information will prevent my application from being reviewed and acted upon.

I hereby certify that the information contained herein and all supporting materials is true and complete, including my NPI (if applicable), which is a component of the credentialing process, to the best of my knowledge and belief. I further understand that my application will be reviewed based upon the information I have provided and other information obtained by Delta Dental in accordance with its credentialing program. I further understand that information which is found to be false or misleading could result in denial or termination of my credentialed status with Delta Dental and in liability for civil damages caused by my providing false or misleading information.

I agree to notify Delta Dental within ten calendar days of my becoming aware of any facts or events that are inconsistent with the answers I provided in my application or that relate to subsequent events pertinent to the questions I originally answered in my application, including, but not limited to, the initiation, progress, and/or conclusion of any disciplinary action by any healthcare plan, facility or regulatory authority.

_____

Owner - Print Name

_____ ___/___/___

Owner - Signature **Date**

IV. AUTHORIZATION AND RELEASE

1. I authorize Delta Dental of New Jersey, Inc., to consult with any person or entity, including but not limited to the National Practitioner Data Bank, who has information bearing on my competence, character, and ethical qualifications and to inspect such records which shall be material to the evaluation of my professional qualifications and competence.

2. I authorize the dental licensing agencies in any state in which I am or have been licensed to practice dentistry, and any health care facility, health maintenance organization, professional organization or individual with whom I have had employment, practice, association or privileges, to release information to Delta Dental of New Jersey, Inc. regarding my professional skills, any pending or final disciplinary action or malpractice action, and any other information relevant to my character or professional competence.

3. I authorize and request my current and prior malpractice liability insurance carriers to release information to Delta Dental of New Jersey, Inc. regarding existing coverage and limits, renewal of same and any claims or actions for damages pending or closed during the previous ten years, whether or not there has been a final disposition.

4. I release from liability a) any person or entity who, in good faith and without malice, provides information to Delta Dental of New Jersey, Inc. for the purpose of evaluating my application, credentials and qualifications; and b) Delta Dental of New Jersey, Inc. for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications.

_____

Owner - Print Name

_____ ___/___/___

Owner - Signature **Date**