First Dental Health

Subject: Re-Credentialing for the First Dental Health Network

Thank you for being part of the First Dental Health Network. To maintain the quality of our network and remain compliant, you are required to provide us complete current credentialing information when requested.

Please complete the attached Re-Credentialing Forms and provide copies of the documents requested below to prevent termination from ALL First Dental Health Networks at ALL locations. Once terminated, all claims will be processed as out-of-network.

______ Complete the following attached **Re-Credentialing Form**

______ Copy of your **Federal DEA Registration** if applicable

______ Copy of your **Board Specialty Certification** if applicable

______ Copy of your **Current Professional Liability Insurance** declaration page/face sheet

Please mail, fax or email your updated Re-Credentialing Form to:

First Dental Health
Attn: Network Development
P.O. Box 919029
San Diego, CA 92191
FAX: 866-613-6381
Email: ProviderRelations@firstdentalhealth.com

If you have any questions, please feel free to contact us at 800-334-7244, Monday to Friday 8:00am - 5:00pm PT.

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Re-Credentialing Update Form

To avoid disruption of your network status, please complete ALL information on this form.

Dentist Full Name: ________________________ ☐**D.M.D.** ☐**D.D.S.** **License #:**___________

Address (Street, City, State, and Zip Code**):** ____

Social Security #: ___________________________ **Date of Birth:** ______________________
(Provider Social Security number is required - no dashes) *(MM/DD/YYY DOB is required)*

DEA

Do you currently hold an active Federal DEA Registration? ☐ **Yes** ☐ **No**

If yes, please complete and include a copy:

Federal DEA Registration #: ______________________________ **Expiration Date:** _________________

Specialty Training ***(please include a copy of applicable certifications)***

Specialty: _____________________________

Are You Currently Board Certified: ☐ **Yes** ☐ **No** **Year Certified:** ________ **Year Expired:** ________

Current Professional Liability Insurance Information
(Must include copy of the current declaration page/face sheet)

Professional Liability Carrier: ____

Effective Date: ________________ **Expiration Date:** __________ **Policy #:** ______________________

Liability Limit: ***(each claim)*** ___________________________ ***(Aggregate Claim)*** _________________________

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Additional Questions:

Yes ☐ No ☐ 1. Has your professional license, DEA or any other certifications you hold to practice dentistry, been suspended, revoked, been made subject to limitations, or have any proceedings to do so been initiated within the last 3 years?

Yes ☐ No ☐ 2. Have you had any restriction or the loss of any hospital or health-care facility staff memberships or privileges since your last appointment?

Yes ☐ No ☐ 3. Has your professional liability insurance been suspended, canceled or not renewed in the last 3 years?

Yes ☐ No ☐ 4. Are you now, or have you in the past 3 years been involved in any malpractice suit, action or arbitration, or has any settlement been paid by you or paid on your behalf in the past 3 years?

Yes ☐ No ☐ 5. Do you currently have any physical or mental impairment or condition that, with or without accommodation, would make you unable to perform the essential functions of a practitioner in your area of practice or unable to perform such essential functions with a direct threat to the health and safety of others?

Yes ☐ No ☐ 6. In the past 5 years up to and including the present, have you ever had a chemical dependency or substance abuse problem?

Yes ☐ No ☐ 7. In the past 3 years up to and including the present, have you been convicted of a crime (other than a traffic offense), or are you currently under indictment for an alleged crime?

Question Explanation- use this space (or a separate sheet) to explain any answers marked "yes".

Date of Occurrence: _________ **Settlement Date:** _________ **Settlement Amount:** ________________

Explanation: ____

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Status: ☐ Pending ☐ Settled ☐ Dismissed

By signing this form I attest that all of the information on this form is correct and complete.

I authorize First Dental Health (FDH) and its clients, to obtain information from others including state license authorities, certification boards, professional liability insurance (including claims histories and loss reports), hospitals, substance-abuse programs, and health-care-related employers, about my qualifications, including, without limitation, my professional competence and conduct.

Signature: ____ **Date:** ________________

(Dentist Signature Required)

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