

# DDS CARENET PARTICIPATING DENTIST APPLICATION

**Please type or print**

Name	Last	First	Middle	Title
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Tax Identification Number	Social Security #	DEA #
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License Number(s)/State(s)	Liability Policy Coverage Amounts/Policy #
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Primary Office Address/Telephone

Secondary Office Address/Telephone

Billing Address/Telephone

Specialty Applying as <input type="checkbox"/> General Dentist <input type="checkbox"/> Specialist (please list)	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Limitations:	Office Contact/Title/Telephone/Email Address
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**Please read AND initial each statement:**

\_\_\_\_\_ 1. I am duly licensed to practice dentistry in the state(s) listed on this Participating Dentist Application.

\_\_\_\_\_ 2. I do not now have, nor have I had in the past five (5) years, any malpractice claims or legal actions brought against me. If you cannot affirm this statement:

- a. Patient's name;
- b. Diagnosis;
- c. Date of incident, date filed, date closed;
- d. Your involvement in the case. (Attending, Consulting, etc.)
- e. Nature of the allegations (s);
- f. Medical facts;
- g. Patient outcome;
- h. Other pertinent details;
- i. Resolution of the case;
- j. Settlement amount on your behalf (if applicable)

\_\_\_\_\_ 3. There are no professional misconduct proceedings or peer review-type proceedings pending wherein I am a party in this state or in any other state or country.

\_\_\_\_\_ 4. There have been no judgments, settlements, findings, decisions or any other determinations of any kind whatsoever entered or made in any professional misconduct proceedings or peer review-type proceedings wherein I was part in this state or any other state or country in the past five (5) years.

\_\_\_\_\_ 5. My license to practice dentistry in any state or country has never been suspended, revoked, or subject to limitations or voluntary relinquishment.

\_\_\_\_\_ 6. I am not currently under investigation nor have any charges been brought against me by any other health care institution third party payor, Medicaid or Medicare, or governmental licensing or other authority.

\_\_\_\_\_ 7. I am not now, nor have I ever been treated for a physical or mental health condition, including alcohol or substance abuse, which would interfere with my ability to perform my duties as a physician.

\_\_\_\_\_ 8. My license to prescribe narcotics has never been voluntarily relinquished nor involuntarily refused, suspended or revoked.

\_\_\_\_\_ 9. I have never been denied participation in, nor terminated from a managed care organization.

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**IF, FOR ANY REASON, YOU CANNOT AFFIRM TO A PARTICULAR STATEMENT WITH RESPECT TO STATEMENTS 2 THROUGH 8 ABOVE,  
SUBMIT FULL DETAILS ON A SEPARATE SHEET.**

I hereby affirm and represent that all statements, answers, and information contained in this application are true, correct and complete to the best of my knowledge and belief and that no information of an adverse nature has been knowingly withheld. I understand that misrepresentation or omission of any fact requested may result in automatic termination. I further understand and agree that acceptance of this application does not constitute approval or acceptance of participation status in \_\_\_\_\_ and grants me no rights or privileges until such time as I receive a formal notice of participation.

My signature on this application indicates my agreement to cooperate fully with \_\_\_\_\_ and its representatives during the processing of this application and any subsequent recredentialing. I further indicate my willingness to provide documentation and other written or oral information as may be requested of me with regard to my application.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print or Type)

**AUTHORIZATION AND RELEASE OF INFORMATION**

I specifically authorize \_\_\_\_\_ or its authorized representative to consult with and obtain any information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for appointment or renewal of appointment to the medical staff, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties relating to such questions.

I specifically authorize and consent to the release of information including otherwise privileged or confidential information to \_\_\_\_\_ by any hospital or hospital's medical staff, medical associations, National Practitioner Data Bank, State Department of Social Services, State Department of Health, other government agencies, malpractice insurance carriers and previous and present and over interested parties regarding information concerning me. I hereby release \_\_\_\_\_, its staff, as well as the institution(s) or organization(s) providing such information and their staff, from any and all liability for the obtaining and release of such information. I also understand I have a continuing obligation to amend and update my answers.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print or Type)