

## Recredentialing packet

Participating dentists are required to recredential every three years. The Professional Relations team at Delta Dental of Virginia will reach out to Virginia dentists when it is time to recredential.

**Upon receipt of notification, please submit the below recredentialing documents at your earliest convenience:**

- Individual Practitioner Profile form signed and dated by the dentist
- Proof of current malpractice insurance (showing the dentist's name and policy date range)
- A copy of your Virginia DEA license or signed DEA Waiver
- Completed practitioner five year work history form
- EFT direct deposit enrollment form if not already enrolled

Completed recredentialing information can be emailed to [Credentialing@deltadentalva.com](mailto:Credentialing@deltadentalva.com), or faxed to 540.491.9702.



# Individual practitioner profile

Complete this form in its entirety and **email it to ProfessionalRelations@deltadentalva.com** or fax it to 540.491.9709.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
First name                      Middle name                      Last name                      Date of birth

Other names used, if applicable

Gender:  Female  Male  Private  Nonbinary

Race/ethnicity:  American Indian or Alaska Native  Asian  Black or African American  
 Hispanic or Latino  Native Hawaiian or Other Pacific Islander  White  
 Prefer not to disclose

\_\_\_\_\_  
Virginia Dental License Number                      National Provider Identifier Number (NPI)

\_\_\_\_\_  
Dentist email address

\_\_\_\_\_  
Office email address

\_\_\_\_\_  
Recredentialing email address

\_\_\_\_\_  
Dental school attended                      Year of graduation

\_\_\_\_\_  
Name of specialty, if applicable                      Specialty program completed                      Year of graduation

Are you a Board Certified specialist?  Yes  No **(Certificate is required — please attach a copy)**

Do you administer any level of anesthesia other than local anesthetic or nitrous oxide sedation?  
 Yes  No **(Anesthesia Permit is required — please attach a copy)**

The American Academy of Pediatric Dentists defines special health care needs to be any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs.

Do you treat children who are intellectually disabled or have special needs?  Yes  No

Do you treat adults who are intellectually disabled or have special needs?  Yes  No

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INDIVIDUAL PRACTITIONER PROFILE (CONTINUED)

- 1. Have any malpractice claims or suits ever been filed against you?
2. Has your professional license in any state ever been denied, revoked, limited, suspended, put on probation or voluntarily relinquished?
3. Has your DEA permit ever been denied, revoked, limited, suspended, or voluntarily relinquished?
4. Have you ever been convicted of a criminal offense?
5. Have you ever been disciplined by a state board of dental examiners or a misconduct board?
6. Have you ever been subject to peer review action?
7. Have you ever had, or do you currently have, a chemical dependency or substance abuse condition?
8. Do you have any mental or physical condition that results in an inability to perform the essential functions of your profession, with or without accommodation?
9. Do you now or have you ever had any sanctions against you by the Office of Inspector General (OIG), Medicare and/or Medicaid?
10. Are you eligible for DEA or CDS certification?
11. If applicable, are your hospital privileges in good standing?
12. Does your office use infection control and barrier techniques according to CDC standards?
13. Does your office clean and heat sterilize high-speed, air-driven hand pieces and prophylaxis angles after each patient?
14. Do you take initial medical/dental history with periodic updates?
15. Do you routinely use a dental or medical consent form for treatment?

If you answered "yes" to questions one through seven, please provide dates, circumstances and dispositions on a separate sheet of paper.

I hereby certify that the information provided and the answers to the questions on this profile are accurate and complete. I agree to immediately notify Delta Dental of Virginia in writing of any changes, including any changes to my professional liability insurance. I hereby give Delta Dental permission to request information from other entities regarding my professional credentials and qualifications. This release of information will not remain valid in the event the Participating Dentist Agreement is terminated.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# DEA registration waiver for dentists

Choose the option that applies to you:

I currently do not have a DEA registration. If, in the course of dental treatment, I believe the patient requires a medication that would need to be prescribed by a DEA registered professional, the following provider is licensed in Virginia and will write prescriptions for patients within my practice:

\_\_\_\_\_  
Prescribing dentist first and last name

\_\_\_\_\_  
Prescribing dentist DEA number

\_\_\_\_\_  
Prescribing dentist license number

I do not prescribe medications for the following reasons:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## DENTIST INFORMATION AND AUTHORIZATION

\_\_\_\_\_  
Dentist first and last name

\_\_\_\_\_  
Virginia license number

By signing below, I certify that all information contained herein is complete and accurate to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Return completed form to:

- **Email:** [ProviderRelations@deltadentalva.com](mailto:ProviderRelations@deltadentalva.com)
- **Fax:** 540.491.9709

# Practitioner five year work history\*

Complete this form in its entirety.

Provider Name \_\_\_\_\_ Virginia Dental License Number \_\_\_\_\_

**Practice/Employer Name** \_\_\_\_\_

Employer Address \_\_\_\_\_

Date of employment, from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**Practice/Employer Name** \_\_\_\_\_

Employer Address \_\_\_\_\_

Date of employment, from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**Practice/Employer Name** \_\_\_\_\_

Employer Address \_\_\_\_\_

Date of employment, from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**Practice/Employer Name** \_\_\_\_\_

Employer Address \_\_\_\_\_

Date of employment, from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**Explanation for gaps in work history:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*Curriculum vitae, résumé or other documents stating work history are acceptable, as long as gaps in work history are explained within those documents or submitted separately on this form.

Complete this form in its entirety and **email it to ProfessionalRelations@deltadentalva.com** or fax it to 540.491.9709.

Reason for submission: <input type="checkbox"/> <b>New EFT/ERA authorization:</b> complete A, B, C, D, E and H <input type="checkbox"/> <b>Cancel EFT/ERA:</b> complete A and G <input type="checkbox"/> <b>Changes to an existing EFT/ERA authorization:</b> complete A, B, C, E, F and H			
<b>A. Office information</b>			
Provider's complete legal name		Practice name	
Address	City	State	Zip
Phone (     )	Fax (     )		
Name of office contact		Email address for payment notifications	
Provider National Provider Identifier (NPI), if applicable		Office Tax Identification Number (TIN)	
Provider license number		Issuing state	
<b>Please indicate which locations you would like to have this Direct Deposit Form include:</b> <input type="checkbox"/> Only this location <input type="checkbox"/> All locations <input type="checkbox"/> I will attach the address of the locations			
<b>B. Banking/financial institution information (please print or type)</b>			
Financial institution's name		Account number	Routing number
Address	City	State	Zip
Phone (     )	Type of account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		
<b>C. EFT/ERA enrollments</b>			
<input type="checkbox"/> Opt-in to National EFT/ERA: Receive electronic payments from Delta Dental of Virginia and all other Delta Dental member companies. <input type="checkbox"/> Opt-out to National EFT/ERA: Receive electronic payments from Delta Dental of Virginia only. If you select this option, you will receive paper checks from all other Delta Dental member companies.			
<b>D. EFT/ERA consent</b>			
<p>In consideration for the provision of direct deposit services, by signing below, and notwithstanding any language to the contrary herein, you hereby acknowledge and agree that (i) any information you have provided, including but not limited to, the information you supplied under the heading "Banking/Financial Institution Information" above, may be transferred, shared or otherwise provided by us to or with any entity that is an affiliate of Delta Dental, as defined above, with other Delta Dental member companies and their affiliates, and with Delta Dental Plans Association, for use in connection with funds to be deposited to your account, (ii) any election to discontinue enrollment in this direct deposit program will take thirty (30) business days to process, and may not be effective to halt any deposits that were initiated while your enrollment in this direct deposit program was in effect, and (iii) in the absence of gross negligence or willful misconduct, neither we, any of our members and affiliates, other Delta Dental member companies and their affiliates, or Delta Dental Plans Association, will be responsible for any damages, or for any fee, charge or other expense assessed against the Bank Account identified above, in connection with this direct deposit program. Further, by signing below, you represent and warrant that (i) all of the information you supplied is true and accurate, (ii) the information provided under the heading "Banking/Financial Institution Information," above, identifies a bank account held by the Business you identified above, and (iii) the signatory to this Direct Deposit Enrollment Form ("Form") has all necessary power and authority to execute this Form. Contact your financial institution to arrange for the delivery of the CORE-related Minimum CCD+ Data Elements necessary for successful re-association of the EFT payment with the ERA remittance advice.</p>			

CONTINUED ON NEXT PAGE

### E. New authorization

I authorize and request Delta Dental of Virginia to send the net claims check directly to my bank or other financial institution as specified in Section B of this form. I understand that by doing this, I will begin receiving an ERA statement as an Explanation of Benefits (EOB). I understand I may terminate this agreement at any time by completing another "Direct Deposit Authorization" or in any event by sending a thirty (30) day written notice to terminate (with new request/instructions for future payment).

Dentist Signature \_\_\_\_\_ Date signed \_\_\_\_\_

### F. Change authorization statement

I authorize and request Delta Dental of Virginia to make the changes indicated on this form. I will allow Delta Dental of Virginia thirty (30) days from date of receipt of this document to accomplish these changes.

Dentist Signature \_\_\_\_\_ Date signed \_\_\_\_\_

### G. Cancellation statement

I authorize and request Delta Dental of Virginia to terminate authorized direct deposits to my account. By doing this, I understand that I will no longer receive an Explanation of Benefits (EOB) through an ERA statement. I understand that all future payments will be made via a paper check and that ERA statements will come in the form of a paper EOB. I will allow Delta Dental of Virginia a thirty (30) day notice from receipt date of this document to accomplish these changes. Unless otherwise noted, upon such cancellation, (future) payments will be made to the participating dentist.

Dentist Signature \_\_\_\_\_ Date signed \_\_\_\_\_

### H. This step is EXTREMELY important and required for your application to process.

To complete your application, attach one of the below:

- Voided check     Letter from your bank (on letterhead) with account and routing numbers

### FOR INTERNAL USE ONLY

Phone number	Contact name
Date	Time
<input type="checkbox"/> Pay to email	<input type="checkbox"/> System match
<input type="checkbox"/> New bank name	<input type="checkbox"/> New account number, last 4 digits:
<input type="checkbox"/> Prior bank name	<input type="checkbox"/> Prior account number, last 4 digits:
Pay to address:	
Professional Relations representative	
Auditor	Audit date