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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, or faxed to 540.491.9702.

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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

Continued on next page

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INDIVIDUAL PRACTITIONER PROFILE (CONTINUED)

1. Have any malpractice claims or suits ever been filed against you? ☐ Yes ☐ No

2. Has your professional license in any state ever been denied, revoked, limited, suspended, put on probation or voluntarily relinquished? ☐ Yes ☐ No

3. Has your DEA permit ever been denied, revoked, limited, suspended, or voluntarily relinquished? ☐ Yes ☐ No

4. Have you ever been convicted of a felony or criminal offense? ☐ Yes ☐ No

5. Have you ever been disciplined by a state board of dental examiners or a misconduct board? ☐ Yes ☐ No

6. Have you ever been subject to peer review action? ☐ Yes ☐ No

7. Are you addicted to, or do you excessively use alcohol, drugs or toxic or foreign agents that tend to limit or adversely affect the performance of your professional duties and responsibilities? ☐ Yes ☐ No

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? ☐ Yes ☐ No

9. Do you now or have you ever had any sanctions against you by the Office of Inspector General (OIG), Medicare and/or Medicaid? ☐ Yes ☐ No

10. Are you eligible for DEA or CDS certification? ☐ Yes ☐ No

11. If applicable, are your hospital privileges in good standing? ☐ Yes ☐ No

12. Does your office use infection control and barrier techniques according to CDC standards? ☐ Yes ☐ No

13. Does your office clean and heat sterilize high-speed, air-driven hand pieces and prophy angles after each patient? ☐ Yes ☐ No

14. Do your patients complete an initial medical/dental history with periodic updates taken either electronically or via paper form? ☐ Yes ☐ No

15. Do you routinely use a dental or medical consent form for treatment? ☐ Yes ☐ No

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

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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:** ProfessionalRelations@deltadentalva.com
- **Fax:** 540.491.9709

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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.

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EFT direct deposit form

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

Reason for submission:

☐ **New EFT/ERA authorization**: complete A, B, C, D, E and H ☐ **Cancel EFT/ERA**: complete A and G

☐ **Changes to an existing EFT/ERA authorization**: complete A, B, C, E, F and H

A. Office information

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		

Please indicate which locations you would like to have this Direct Deposit Form include:

☐ Only this location ☐ All locations ☐ I will attach the address of the locations

B. Banking/financial institution information (please print or type)

Financial institution's name	Account number	Routing number	
Address	City	State	Zip
Phone ( )	Type of account: ☐ Checking ☐ Savings		

C. EFT/ERA enrollments

☐ Opt-in to National EFT/ERA: Receive electronic payments from Delta Dental of Virginia and all other Delta Dental member companies.

☐ 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.

D. EFT/ERA consent

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 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.

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 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 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 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
☐ Pay to email	☐ System match
☐ New bank name	☐ New account number, last 4 digits:
☐ Prior bank name	☐ Prior account number, last 4 digits:
Pay to address:	
Professional Relations representative	
Auditor	Audit date