Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Arkansas Blue MEDICARE
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

Application to Join Our Dental Networks

Completed Form can be emailed to dentalproviderrelations@usablelife.com or faxed to 501-208-8302.Forms can also be mailed to: PO Box 1650 Little Rock AR 72203.

PERSONAL INFORMATION

Dentist's:
Last Name_____First_____MI:_____Suffix:_____Degree: _____

Date of Birth: _____/_____/_____ Month Day Year	Gender: ☐ Female ☐ Male	License#:_____ State of License: _____ Expiration Date: _____	DEA #: _____ Expiration Date: _____ Specialty:
Social Security Number:	Dentist's Individual Type 1 NPI:		

Specialty Board Certificate Status ☐ No ☐ Certified ☐ Eligible ☐ N/A	Board Certification (if applicable) Effective and Expiration Dates_____to_____

Education: General Practice	School:	Location:	Mo/Yr. Graduated /
Education: Specialty Training	School:	Location:	Mo/Yr. Graduated /

OFFICE AND BILLING INFORMATION

Practice Name (as shown on W-9)	
Practice TIN:	☐ Group ☐ Individual ☐ Sole Proprietor
Group Name (if applicable)	Group Type 2 NPI:
Primary Practice Location Telephone Number:	Primary Practice Location Fax Number:
E-mail Address:	Website:
Physical Address:	Physical City/State/Zip Code:
Billing Address if different than Physical Address above:	Billing City/State/Zip Code:
Mailing Address if different than Physical Address above:	Mailing City/State/Zip Code:
Languages (including Sign Language) spoken by provider, staff or interpreter:	

Does your office have TDD service for patients with hearing impairments?	☐ Yes	☐ No
Is your office accessible by public transportation?	☐ Yes	☐ No
Is your office handicapped accessible?	☐ Yes	☐ No
Does your office have weeknight hours?	☐ Yes	☐ No
Does your office have weekend hours?	☐ Yes	☐ No

WORK HISTORY

Beginning with your current location, please provide an up-to-date professional work history for the past five (5) years. Remember to include month and year for each entry. Please include dates and explanations for any significant gaps (more than 6 weeks) in your work history. Use an additional page if needed.

From: _____ _____
(Month) (Year)

Name of Current Practice:

Address:

City, State, Zip Code:

Phone Number:

Name of Immediately Preceding Practice or Activity:

From: _____ _____ To: _____ _____
(Month) (Year) (Month) (Year)

Address:

City, State, Zip Code:

Phone Number:

Name of Immediately Preceding Practice or Activity:

From: _____ _____ To: _____ _____
(Month) (Year) (Month) (Year)

Address:

City, State, Zip Code:

Phone Number:

Name of Immediately Preceding Practice or Activity:

From: _____ _____ To: _____ _____
(Month) (Year) (Month) (Year)

Address:

City, State, Zip Code:

Phone Number:

PRACTICE HISTORY — This section must be completed by the applicant

Please complete the questions below regarding your malpractice history. For each *yes* answer, please attach a detailed explanation.

1. Have there been or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice?	☐ Yes	☐ No
2. Has your license to practice dentistry in any jurisdiction ever been denied, limited, suspended, revoked, or otherwise conditioned?	☐ Yes	☐ No
3. Has your membership in any local, state or national professional society or organization ever been revoked or suspended? Are revocation or suspension activities presently pending, or have been denied membership or renewal in any such society or organization?	☐ Yes	☐ No
4. Has your medical membership, medical privilege, or medical staff status at any hospital been granted with limitations, suspended, revoked, not renewed, denied, or subject to probationary conditions, or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?	☐ Yes	☐ No
5. Has your controlled substance registration ever been denied, revoked, suspended, reduced or not renewed: or have proceedings towards those ends ever been instituted or are presently pending?	☐ Yes	☐ No
6. Have you been denied membership or renewal thereof, or been subjected to disciplinary action by any dental organization?	☐ Yes	☐ No
7. Have you been the subject of any BCBS, Medicare, Medicaid (any state) or other dental reimbursement plan suspension or probation proceedings, or restricted from receiving payments from any BCBS, Medicare, Medicaid (any state), or other third-party programs?	☐ Yes	☐ No
8. Have you been the subject of any disciplinary actions by state or local dental societies, any state board of registration or examiners, or the DEA?	☐ Yes	☐ No
9. Have you ever been convicted of a felony, or are felony proceedings or indictments presently pending?	☐ Yes	☐ No
10. Have you ever been denied professional liability insurance, or have you ever had professional liability insurance cancelled?	☐ Yes	☐ No

HEALTH STATUS

1. Do you currently have, or have you previously had, any physical or mental health condition, including drug or alcohol dependency, that could reasonably impact your ability to practice dentistry? If yes, please attach a full explanation.	☐ Yes	☐ No
2. Are you unable to perform the procedures and the essential functions of dentistry, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients? If Yes, please attach a full explanation.	☐ Yes	☐ No

ORAL SURGEONS ONLY

Do you have any hospital privileges and/or affiliations? If Yes, please list all current privileges and/or affiliations:	☐ Yes	☐ No

_____

Hospital Name

_____

City/State

_____

Start Date

MEDICARE PARTICIPATION ☐ Yes ☐ No

REQUIRED ATTACHMENTS FOR ALL

Attach photocopies of:

- ☐ Professional Liability Insurance Certificate (current)
- ☐ State License (current)
- ☐ Permits for anesthesia (as applicable for oral surgeons).
- ☐ Prescription Monitoring Registration
- ☐ DEA Registration
- ☐ Specialty Board Certificate
- ☐ Curriculum Vitae
- ☐ CMS Attestation Form

AFFIRMATION AND CONSENT TO RELEASE INFORMATION **To be completed by *all* applicants**

Affirmation Statement

I (the "**Applicant**") represent that the information set forth in this Dentist Application (this "**Application**") is and shall remain true, accurate and correct in all material respects throughout the period during which USAble Life evaluates my Application and, if it accepts me as a Network Dentist, in accordance with the term of the Dental Network Participation Agreement ("**Agreement"**).
The Applicant acknowledges and agrees that s/he shall notify USAble Life in a timely manner of any material changes in the information set forth in this Application occurring during the evaluation period and, if applicable, the term of the Agreement. The Applicant acknowledges that USAble Life may reject this Application or terminate the Agreement if it: (1) discovers any material omission or misstatement concerning any of the information set forth in this Application or (2) it is subsequently notified of a material change in such information.

If USAble Life, in its sole discretion, accepts the applicant as a Network Dentist, this Application shall be attached to and incorporated into the Agreement. The Dentist acknowledges and agrees that the Agreement shall be binding upon the parties only on and after its Effective Date, which shall be the date upon which the Agreement is signed by a representative of USAble Life.

Consent to Release Information

All information submitted by me in this application is true to my best knowledge and belief. I understand that this application does not create any right or expectation that I will be accepted by USAble Life as a Network Dentist.

I authorize USAble Life and its Representatives to consult with persons or entities ("**Persons**") to obtain and verify information concerning my professional competence, conduct, character, moral and ethical qualities, experience or other any other matters that USAble Life deems to be relevant in evaluating my Application (my "**Qualifications**"). I release USAble Life, such Persons and their respective Representatives from any and all liability for any and all non-malicious acts or omissions arising from or related to the provision, receipt, verification or evaluation of information pertaining to my Qualifications to become a Network Dentist.

I consent to permit Persons contacted by USAble Life or its Representatives to release any and all information or documents to USAble Life that it, in its discretion, may find relevant to an evaluation of my Qualifications, including without limitation: information or documents relating to any disciplinary action, suspension or curtailment of my license or privileges; and reports or summaries by professional liability insurance carriers relating to my insurance coverage's and or professional liability loss experience

I acknowledge that I have the burden of demonstrating my Qualifications to serve as a Network Dentist both now and in the future. Any dispute related to this Application shall be resolved in accordance with the Dispute Resolution Procedure section of the Dental Manual and, if USAble Life substantially prevails in any action pursuant to that Procedure, I shall reimburse USAble Life for any and all expenses incurred in connection with that action, including its attorneys' fees.

This Consent shall remain in full force and effect and may be relied on by those Persons providing information to USAble Life unless and until it is specifically revoked by me in writing. Any such revocation shall not apply retrospectively. A photocopy of this authorization shall be as effective as the original when presented.

Dentist:

By: _____
(Print name)

Title: _____

Signature: _____

Primary Physical Address: _____

Date of Signature: _____