

CREDENTIALING APPLICATION



Horizon Blue Cross Blue Shield of New Jersey

**This Credentialing Application cannot be processed until it is completed in FULL
Please maintain a copy of this Credentialing Application for your records
Information provided in this application must be consistent with information submitted on your claims**

Credentialing Application is complete when:

- The Credentialing Application has been updated in its entirety, signed and dated (NO STAMPED SIGNATURES)**
- Current Copies** of the following have been **attached**:
 - ✓ **Dental License** (provide copies for EVERY state in which you are licensed)
 - ✓ **Federal DEA Registration** for **EVERY STATE** the DDS is participating in.
 - ✓ **American Board/Specialty Certificate** (if applicable)
 - ✓ **Controlled Dangerous Substance (CDS)** certificate for **EVERY STATE** the DDS is participating in.
 - ✓ **Professional Liability Insurance Declaration Page** – showing minimum coverage of \$1 million/\$3 million, dentist's name, policy #, effective and expiration dates.
 - **If expiration date** is within weeks of this application, updated documentation must be submitted.
- W-9 Form or Employer Identification Number Letter (EIN)**
- Facility Profile**
- Automated Clearinghouse Authorization Agreement**

If you are a dentist seeking credentialing for a new office location, call Customer Service at 1-800-433-6335. You will be given the contact information for your Network Representative to obtain a Participating Location Group Dental Agreement. This agreement is required to participate in our network.

MAIL CREDENTIALING APPLICATION TO:

Horizon Professional Services

Attn: Credentialing

PO Box 153

Minneapolis, MN 55440-9886

or email to: Horizoncredentialing@decare.com

You also have the option of faxing this information to us at: 1-855-311-1373

Questions? Call (toll free) 1-855-648-1408

Notice of Applicant's Right

You may review or request the status of your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable State laws. If there are discrepancies in the information received during the credentialing process, you will be notified and allowed an opportunity to correct erroneous information submitted by another party within thirty (30) days of submitting your application. This includes information submitted by an outside primary source, such as Professional Insurance Carrier, State License Board and/or the National Practitioner Data Bank.

Confidentiality Statement

Information gathered as part of the credentialing or re-credentialing process is maintained in a confidential manner and will not be communicated or reproduced. This provision is designed to safeguard information and ensure confidentiality.

DEMOGRAPHICS (Please type or print) **STATE DENTAL LICENSE #:** _____

Name:	_____
	<div style="display: flex; justify-content: space-between;"> Last First MI </div>
Social Security Number:	_____ - _____ - _____
Select One:	<input type="checkbox"/> Owner <input type="checkbox"/> Partner <input type="checkbox"/> Associate
State Medicare Number:	_____
	Medicaid Number: _____
UPIN Number:	_____
Children's Health Insurance Plan (CHIP) #:	_____
(Individual) NPI Number:	_____
Date of Birth:	____/____/____
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Do you currently hold a Federal DEA registration?	<input type="checkbox"/> YES (Submit copy) <input type="checkbox"/> NO
Languages Spoken Fluently	

GENERAL DENTISTRY EDUCATION

Institution	Grad Date	Degree
-------------	-----------	--------

SPECIALTY EDUCATION

Institution	Grad Date	Degree
-------------	-----------	--------

For the above **SPECIALTY**, I am:

- Educationally Qualified (showing institution **name, grad yr, and specialty**)
- AMERICAN Board Certified *** (attach certificate copy from **American Board**)

* Date of Certification: _____ Expiration Date: _____

PROFESSIONAL LIABILITY INSURANCE FOR EACH ENTITY IN WHICH YOU PRACTICE AT
(Complete information below OR attach copy)

CARRIER:	POLICY #:
COVERAGE LIMITS (Occurrence/Aggregate):	
EFFECTIVE DATE:	EXPIRATION DATE:

The selection process ensures that Credentialing decisions are not based on an applicant's race, ethnicity/nationality, gender, age, sexual orientation, or the types of patients or procedures in which the dentist specializes.

DDS NAME AND STATE DENTAL LICENSE NUMBER (As indicated on your license copy):

PRIMARY PRACTICE LOCATION If more than one location please attach a separate sheet with the below information.

Group/Practice Name:	_____
Street Address (Building; Street; Suite #):	_____
City/State/Zip:	_____ County: _____
Office Phone Number:	(____) _____ ER/After Hours Number: (____) _____
Fax Number:	(____) _____ Office Email: _____
Tax ID Number (TIN): AS LISTED ON W-9	_____ - _____
(Location) NPI Number:	Clinic: _____ Corporate: _____
Office Manager/Contact:	_____
Are office protocols for infection control in compliance with current CDC/OSHA guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No	

CORRESPONDENCE INFORMATION: (If different from primary practice location) This address is used to send communications such as welcome letters and newsletters	BILLING INFORMATION: (if different from primary practice location) This address is for claim reimbursement
Address: _____ _____	Address: _____ _____
Office Manager/Contact	Office Manager/Contact

EMPLOYMENT HISTORY: Chronological listing must include **MONTH and YEAR** for each entry of employment history for the **MOST RECENT 5 years**. List all armed service, public health, education, business or professional activities, sabbatical, etc. **LEAVE NO GAPS IN CHRONOLOGY**

Dates (Month & Year)	Facility and Address	Phone Number & TIN	Reason for Leaving:
From: _____ To: _____ Present	Current Location		
From: _____ / _____ To: _____ / _____			
From: _____ / _____ To: _____ / _____			

PRIMARY ADMITTING FACILITY (List present hospital/surgical center privileges in chronological order beginning with the most recent.)

Primary Admitting Facility:	_____
Type of Status:	_____
Street Address:	_____
City/State/Zip:	_____
Dates (Month/Year):	From: _____ To: _____

DISCLOSURE QUESTIONS

Please complete the Professional Liability Addendum if questions 1-10 are answered in the affirmative.

1. Yes No **Have you ever** had your **professional license, registration or DEA** terminated, stipulated, restricted, limited, conditioned, subjected to corrective action, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?
2. Yes No **Have you ever** had your **membership, participation, clinical privileges, or employment** denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?
3. Yes No **Have you ever** voluntarily/involuntarily relinquished your **membership, participation, clinical privileges or request for privileges, employment, professional license, or registration** as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?
4. Yes No **Have you ever** been reprimanded, censured, or otherwise disciplined by, or have you been subject to a corrective action agreement/plan with any **licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**
5. Yes No **Have you ever** had your certificate or participation in **any private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?
6. Yes No Are there any **charges pending or have you ever** been indicted, found guilty of a felony, misdemeanor (other than minor violations), or other offenses involving fraud, misrepresentation, dishonesty or deceit? Are you currently using illegal drugs?
7. Yes No **Have you ever** been found liable, guilty or responsible for sexual impropriety or misconduct or sexual harassment?
8. Yes No **Have you ever** had any Malpractice (Professional Liability) claims or lawsuits brought against you, including pending, dismissed or dropped claims/lawsuits, settlements or final judgments? (This includes status of any pending claims previously reported.)
9. Yes No **Have you ever** had your Malpractice (Professional Liability) carrier refuse or cancel your coverage?
10. Yes No Do you have a condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing a significant health or safety risk to your patients?
11. Yes No Is your Professional Liability current with limits \$1 million/\$3million?

DISCLOSURE QUESTIONS & DENTIST CONSENT

I hereby certify that to my knowledge that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary while my application is being processed. I agree to notify any changes in malpractice coverage, including changes in the insurance carrier or policy number, as they occur.

By completing this application to become a participating dentist, I fully understand that any significant misstatement in, or omission from, my application to become a participating dentist may constitute cause for denial of my application or the subsequent termination of my participating dentist contract if my application is accepted. I understand and agree that this consent is irrevocable for any period during which I am a participating dentist. Reserved is the right to base acceptance into any individual network based on criteria established.

I understand that my application may require review of information related to me on file with other entities, including but not limited to, state licensing boards, specialty boards, professional societies, malpractice carriers, and the National Practitioner Data Bank administered by the U.S. Government.

I authorize release from liability all representatives, including any agent, my state licensing board, clinics, other institutions, professional societies, professional malpractice insurance carrier(s) and any staff, for their acts performed in good faith and without malice in connection with the gathering and exchange of information as consented above or to release information as required by State or Federal laws, rules, or regulations.

I understand and agree that I have the responsibility of producing adequate information for proper evaluation of my continued professional competence, ethics and other qualifications and for resolving any doubts about such qualifications. I further understand and agree that I have a continuing affirmative duty to immediately inform of any future restrictions or revocation of my professional license, any disciplinary action, suspension or voluntary/involuntary limitation, denial of my clinical or other privileges, or any other event which may adversely reflect upon my professional competence, ethics and other qualifications as a participating dentist.

I understand that subject to proper confidentiality restrictions and authorizations, my dental records will be subject to inspection for quality assurance and utilization review purposes.

Signature _____ **Date** _____

Name _____ **Dental Lic #:** _____

(Please print or type)

Request for Taxpayer Identification Number and Certification

**Give Form to the
 requester. Do not
 send to the IRS.**

Print or type See Specific Instructions on page 2.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification; check only one of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner. <input type="checkbox"/> Other (see instructions) ▶ _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	6 City, state, and ZIP code	
	7 List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number									
				-			-		
or									
Employer identification number									
				-					

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ▶	Date ▶
------------------	----------------------------	--------

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

AUTOMATED CLEARINGHOUSE AUTHORIZATION AGREEMENT



Horizon Blue Cross Blue Shield of New Jersey

Horizon Dental is hereby authorized to credit our bank account through the Automated Clearinghouse (ACH) for the **Total Amount Owed** according to the Claims submitted.

Dentist Name:	First:	Last:
Dentist ID:		
ACH Effective Date:		
Account Name:		
Type of Account:	<input type="checkbox"/> Checking <input type="checkbox"/> Savings	
Bank Name:		
Bank Address:		
Bank Account Number:		
Bank Routing Number:		
(between these symbols ⑆ ⑆ on the bottom left of your check)		
PLEASE INCLUDE A VOIDED CHECK		

AUTHORIZED INDIVIDUAL OF THE ACCOUNT

I understand that this authorization will be in effect until I notify Horizon in writing that I no longer desire this service, allowing it reasonable time to act on my notification.

Name: _____
(Please print or type)

Signature: _____ Date: _____

Title: _____ Office Phone: (_____) _____

**If you have any questions, please call Horizon EFT.
Upon completing this form, please mail or fax it along with a copy of a voided check to:
(651) 406-5934 or toll-free to (877) 201-7345.**

**Or mail to: Horizon Dental BCBSNJ
ATTN: EFT Department
PO BOX 1612
Minneapolis, MN 55440-1612**

EFT Department
toll-free fax: 1-(877) 631-8953
toll-free: 1-(877) 201-7345

Services and products may be provided by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare Dental, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association. Horizon Healthcare Dental Inc. is a subsidiary of Horizon Blue Cross Blue Shield of New Jersey.

The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross and Blue Shield Association. The Horizon® name and symbols are registered marks of Horizon Blue Cross Blue Shield of New Jersey. CMC0006187

© 2014 Horizon Blue Cross Blue Shield of New Jersey, Three Penn Plaza East, Newark, New Jersey 07105.