ProAct Credentialing Application and Checklist

APPLICANT NAME: _____
TYPE OF PROVIDER: _____

In order to expedite the credentialing process, please complete every item on this application. Please, DO NOT write, "See CV" or "Refer to CV" in place of completing the information requested. Please enclose copies of the documentation listed below, and sign and date the Attestation Acknowledgements/Information Release consent page. Thank you for your assistance!

Check the box if enclosed:

- ☐ Current State License/Registration Certificate ***(cannot be less than 30 days prior to the expiration date. A website printout from the Florida Department of Health is not acceptable)***
- ☐ Current DEA Certificate / CDS Certificate (if applicable) ***(cannot be less than 30 days prior to the expiration date)***
- ☐ Current Professional Liability Insurance Certificate face sheet or Financial Responsibility Waiver ***(cannot be less than 30 days prior to the expiration date)***
- ☐ Curriculum Vitae/Resume outlining history (mm/yyyy) since graduation from dental school (gaps over 6 months require an explanation)
- ☐ Copy of Professional Education School Diploma (dental/medical school)
- ☐ Residency Certificate
- ☐ Board Certification or evidence of Board status (if applicable)
- ☐ Additional locations information sheet; enclosed
- ☐ Disclosure of Ownership Completed
- ☐ W9 Form

Mail or fax the application and all documentation to:

ProAct Health Solutions
Network Credentialing Department
2940 Mallory Circle, Suite 201
Celebration, Florida 34747
(800) 570-7414 extension 1762, FAX (321) 250-1762

PROACT PROVIDER CREDENTIALING APPLICATION **DATE: _____**

PLEASE CHECK:

☐ **DDS** ☐ **DMD** ☐ **MD** ☐ **DO** ☐ **OTHER: _____**

I. Personal Information:

_____

Last Name, (Sr. Jr., III, etc) First Name Middle Initial

_____

Home Address

_____

City State Zip Code County

_____ _____ _____/____/_____ ☐ Male ☐ Female

Social Security # Individual NPI Date of Birth Gender

For EEOC Compliance Requirements Only, Please Indicate the Following:

☐Caucasian ☐African American ☐Hispanic ☐Asian

☐American Indian or Alaskan Native ☐Other: _____

II. Office/Practice Information: (Attach additional sheets for multiple office locations)

_____

Name of Primary Practice

_____

Primary Office Address

_____

City State Zip Code County

_____ _____ _____ _____

Office Phone # Office Fax # Alternate # Email Address

Practice Type: ☐Solo Practitioner ☐Group Practice

Tax ID#: _____ Practice NPI #: _____

_____ _____ _____

Office Manager/Contact Owner Year Established

Billing Information:

_____

Remit Name and Address (if different from above)

_____

City State Zip Code County

_____ _____ _____ _____

Billing Phone # Billing Fax # Billing Contact Billing Email Address

Languages Spoken in office: _____

Accepting New Patients: ☐ **Y** ☐ **N** Age Range: from _____ to _____

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Does your office:

X-Ray Machines: ☐ **Y** ☐ **N**

Use Practice Mgt Software: ☐ **Y** ☐ **N** Practice Software Name: _____

Make Provisions for Emergency Coverage: ☐ **Y** ☐ **N**

With Whom: _____ Phone #: _____

Have the Capability for Electronic Billing: ☐ **Y** ☐ **N**

Meet ADA Accessibility Standards: ☐ **Y** ☐ **N**

Utilize: Nitrous Oxide ☐ **Y** ☐ **N** General Anesthesia ☐ **Y** ☐ **N**

Have an answering service: ☐ **Y** ☐ **N**

Does your office?

Comply with OSHA/CDC blood borne pathogen standards in infection control & barrier techniques ☐ **Y** ☐ **N**

Are all your high speed air driven hand pieces, prophy angles and all other metal instruments ☐ **Y** ☐ **N**

Does your office follow OSHA guidelines with respect to bio-hazardous wastes ☐ **Y** ☐ **N**

Does your office see Medicaid Patients? ☐ **Y** ☐ **N**

Does your office see Medicare Patients? ☐ **Y** ☐ **N**

Does your office see Healthy Kids Patients? ☐ **Y** ☐ **N**

Does your office currently assess patients for Obstructive Sleep Apnea? ☐ **Y** ☐ **N**

III. Education: (gaps over 6 months require and explanation)

_____
Name of Undergraduate School

_____
School Address

_____
City State Zip Code County

_____ _____
Degree Awarded Dates Attended – Month/Year

_____
Name of Dental/Medical School

_____
School Address

_____
City State Zip Code County

_____ _____
Degree Awarded Dates Attended – Month/Year

i. Residency/Fellowship:

Specialty: _____ Graduate Institution: _____

_____ _____ _____
Graduation Date Degree City State

ii. Board Certification:

_____ _____
Name of Certifying Board Certification Date

If you are NOT certified, are you Board Eligible? ☐ **Y** ☐ **N**

iii. Hospital Privileges (if applicable)

_____ _____
Hospital Name City State

_____ _____
Hospital Name City State

V. Personal Licensure & Liability Insurance Information:

Dental License Number: _____ State: _____ Expiration Date: _____

Medical License Number: _____ State: _____ Expiration Date: _____

DEA License Number: _____ State: _____ Expiration Date: _____

Medicare#: _____ Medicaid Number: _____

Malpractice Insurance:
(Please Provide Information For All Cases Occurring in Previous 10 yrs. Attach Additional Sheets as Necessary)

Name of Insurance Company: _____

Policy #: _____ Policy Dates: _____

Coverage Amount per Occurrence/Aggregate: _____/_____

Occurrences: _____ Claim(s) Paid: _____ Dates Paid: _____

VII. Work History: (Chronologically, list all positions in the last 5 years on this form. Your CV should list all history since Dental/Medical School. Gaps over 6 months require and explanation.)

_____ _____
Current Employer: Name & Address From (mm/yyyy) / To Present

_____ _____
Former Employer: Name & Address From (mm/yyyy) / To Present

_____ _____
Former Employer: Name & Address From (mm/yyyy) / To Present

_____ _____
Former Employer: Name & Address From (mm/yyyy) / To Present

_____ _____
Former Employer: Name & Address From (mm/yyyy) / To Present

VIII. Professional Questionnaire: (Please Provide an Explanation for Any **YES** Responses on a Separate Page)

1. Has your Dental License, DEA License or any applicable narcotic registration in any jurisdiction ever been denied, limited, reprimanded, sanctioned, suspended, revoked, not renewed, subject to probationary conditions, received any administrative complaint or concerns **OR** is any such action pending? ☐ **Y** ☐ **N**

2. Have your privileges at any hospital, dental organization or other health care setting ever been suspended, revoked, voluntarily surrendered, denied, reduced, restricted, not renewed or has probation ever been invoked? ☐ **Y** ☐ **N**

3. Have you been denied participation, terminated, suspended, fined or otherwise sanctioned or restricted by Medicare/Medicaid, or any other private or public payer, or is any such action pending? ☐ **Y** ☐ **N**

4. Has your professional liability insurance ever been terminated, restricted, special rated, have you been denied professional liability insurance or has your policy ever been cancelled? ☐ **Y** ☐ **N**

5. Has any judgment or settlements been made against you in professional liability cases or are there any filed and served professional liability lawsuits against you pending? ☐ **Y** ☐ **N**

6. Have you ever received sanctions from a regulatory agency (e.g., DOH, SAM, OIG, etc.?) ☐ **Y** ☐ **N**

7. Has any information on you ever been reported to the National Practitioner Data Bank? ☐ **Y** ☐ **N**

8. Do you have any mental or physical conditions impacting your ability to perform the essential functions of the position for which you are applying with or without accommodation? ☐ **Y** ☐ **N**

9. Do you currently have or have you had a chemical dependency/substance abuse problem, treated or untreated which may impact your ability to practice? ☐ **Y** ☐ **N**

10. Within the last five years have you been reprimanded or disciplined in any manner by any State Licensing Authority or other professional board or peer review committee for conduct related to the use of alcohol or use of any illicit drug? ☐ **Y** ☐ **N**

11. Have you ever been convicted of a felony, misdemeanor or been named as a defendant in any criminal case or is any such action pending? ☐ **Y** ☐ **N**

IX. Disclosure of Ownership:

1. Do you have ownership in your existing practice? ☐ **Y** ☐ **N**
2. Do you, your business entity or any family member have an ownership greater than 5% in any other medical enterprise or business? ☐ **Y** ☐ **N**

If ***YES***, please continue in accordance with Federal Regulations 42C.F.R§455.104.

_____	_____	_____
Print Name	Signature	Date

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information			
Name of Entity:			
Business Address:			
City:	State:	Zip:	Telephone#:

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list the names and addresses of individuals or corporations under Remarks on the following page. Identify each item number to be continued	
a) Are there any individuals or organizations having a direct or indirect ownership or control interest of 5% or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organization in any of the programs established by Titles XVIII, XIX or XX?	☐ **Y** ☐ **N**
b) Are there any directors, officers, agents or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX or XX?	☐ **Y** ☐ **N**
c) Are there any individuals currently employed by the institution, agency or organization in a managerial, accounting, auditing or similar capacity who were employed by the carrier within the previous 12 months? (Title XVIII providers only)	☐ **Y** ☐ **N**

III. a) List names and addresses for individuals or the EIN for the organizations having direct or indirect ownership or a controlling interest in the entity. List any additional names and addresses under "Remarks" on the following page. If more than one individual is reported and any of these persons are related to each other, this must be reported under "Remarks".

NAME	ADDRESS	TAX ID# (EIN)

b) Type of entity:

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated Associations

☐ Other (Specify): _____

c) If the disclosing entity is a corporation, list names and addresses of the Directors and EINS for corporations under Remarks.

Check the appropriate box for each of the following questions:

d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (example: sole proprietor, partnership or members of Board of Directors.) If yes, list names and addresses of individuals and provider numbers. ☐ **Y** ☐ **N**

NAME	ADDRESS	PROVIDER #

IV. a) Has there been a change of ownership or control within the last year? ☐ **Y** ☐ **N**
If yes, When? _____

b) Do you anticipate any change of ownership or control within the year? ☐ **Y** ☐ **N**
If yes, When? _____

c) Do you anticipate filing for bankruptcy within the year? ☐ **Y** ☐ **N**
If yes, When? _____

V. Is this facility operated by a management company, or leased in whole or in part by another organization? ☐ **Y** ☐ **N** If yes, When?
_____

VI. Has there been a change in Administrator or Dental/Medical Director within the last year? ☐ **Y** ☐ **N**
If yes, When? _____

VII. a) Is this facility chain affiliated? (if yes, list name, address of Corporation and EIN) ☐ **Y** ☐ **N**

Name: _____
Address: _____
EIN: _____

b) If the answer to Question VII a) is No, was the facility ever affiliated with a chain? ☐ **Y** ☐ **N**

(if yes, list Name, Address or Corporation and EIN)
Name: _____
Address: _____
EIN: _____

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the state agency or the secretary, as appropriate.

_____ _____ _____
Name of Authorized Representative (Typed) & Title Signature Date

Remarks: _____

_____

X. Attestation Acknowledgements/Information Release Authorization:

I hereby give consent to PROACT HEALTH SOLUTIONS to request information regarding my professional credentials and qualifications including but not limited to those information listed above, from educational facilities, hospital(s) in which I currently have or formerly had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, present and past employers, the National Practitioner Data Bank and all other authorities with information regarding me.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter applicable to the credentialing procedure as determined by PROACT HEALTH SOLUTIONS. I release and hold harmless PROACT HEALTH SOLUTIONS and any of its respective officers, directors, representatives, employees, agents and affiliated entities from any and all liability for any damages, costs and expenses which may result from the gathering or use of the information gathered during the credentialing process providing such release of information is done in good faith and without malice.

I agree that the photocopy or facsimile of this release with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I understand that I have the right to obtain the status and to review and correct erroneous information obtained by PROACT HEALTH SOLUTIONS to evaluate my credentialing application at any time after submitting my application. This includes information obtained from primary source (e.g., malpractice insurance carriers, state licensing boards, NPDB, etc.) The review must take place within 6 months of the date on this application. Any corrections must be made in writing within 30 days of the review. This does not require PROACT HEALTH SOLUTIONS to allow me to review references or recommendations or other information that is peer review protected. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of any professional competence, character, ethics and other qualifications and for resolving doubt about such qualifications.

I hereby affirm that the information submitted in this application and any addenda thereto is true to the best of my knowledge and belief and is furnished in good faith. I understand that willful falsification, significant omissions or willful misrepresentations may result in the rejection of my application by PROACT HEALTH SOLUTIONS, termination of my current participation, employment, privileges and provider agreement with the PROACT HEALTH SOLUTIONS Network. I understand that if my application is rejected for reasons relating to my professional conduct or competence, PROACT HEALTH SOLUTIONS may report the rejection to the appropriate state licensing board and/ or NPDB as required.

I understand that this application does not entitle me to participation in PROACT HEALTH SOLUTIONS's Network and I agree that neither PROACT HEALTH SOLUTIONS nor its representatives or any individuals or entities providing information to PROACT HEALTH SOLUTIONS in good faith shall be liable for any act or omission related to the evaluation or verification of the information contained in this application.

I further agree to notify PROACT HEALTH SOLUTIONS in writing within 10 days of receiving any written or oral notice of any adverse action, including without limitation, any filed, served malpractice suit or arbitration action; any adverse action by the Dental/Medical Board taken or pending, including but not limited to, any accusation filed, temporary restraining order or interim suspension order sought or obtained; public letter or reprimand, public reprove, and any formal restrictions, probation, suspension or revocation of licensure; any adverse action taken by any Health Care Organization, which has resulted in the filing of a report with the Dental Board or a report with the National Practitioner Data Bank; any revocation of DEA licensure; a conviction of any felony or a misdemeanor of moral turpitude; any action against any certification under the Medicare/Medicaid programs; or any cancellation, non-renewal or material reduction in dental/medical liability insurance policy coverage.

Information requested in this application that is not publicly available will be treated as confidential by PROACT HEALTH SOLUTIONS. My Signature hereby authorizes the verification of the information I have provided.

Print Name	Signature	Date