Credentialing/ Recredentialing Instructions

What's required?
All Dentists who want to enroll with Delta Dental of Massachusetts must be credentialed AND contracted BEFORE you can begin treating members. To become credentialed you need to submit a completed credentialing application. Incomplete applications cannot be processed.

- If the office you will be participating with is not contracted, one contract for the business (i.e. Tax ID), listing all participating providers and a W-9 is required.

Request enrollment documents at: www.deltadentalma.com · Dentists · Join Our Networks.

How do I get Credentialed and Contracted?
Submit a credentialing application to Delta Dental of Massachusetts (DDMA).
Sign the relevant contract for the network(s) you want to join, send the executed contracts to DDMA and wait for DDMA to send you a copy if the agreement(s) counter-signed by DDMA

Please Note: Delta Dental of Massachusetts does not accept providers with Federal Sanctions.

Complete Delta Dental of Massachusetts's Provider Application and Submit via:
E-Mail – DeltaDentalProviderEnrollment@deltadentalma.com
Or
Fax: 617-886-1414

Important Tips and Reminders
- ✓ Submit your application as soon as possible.
- ✓ Certification, Statement, and Signature Page – Please read the statement carefully. Sign, hand written signature (no stamps) and date this page. Signature may not be older than 120 days old.
- ✓ Credentialing Contact Information – Name, phone number, email address.
- ✓ Required Documents- Check that all the information you provide is current (ex. Mal-practice insurance). Throughout the process, we may be contacting you. Please respond as quickly as possible to avoid expiration of documents.
- ✓ Submit application with all applicable sections completed. If something does not pertain, indicate N/A, except for the items marked with an asterisk (*). Do not leave any fields blank.
- ✓ Keep a completed copy of your application for your records.

Application Checklist

Dear Provider:

It is our intention to provide a streamlined credentialing/ recredentialing process. To guide you through the process, prior to sending us your application, please **use the checklist below to ensure you have sent us all the required items**. **Incomplete applications cannot be processed.**

- **Email address must be supplied – this email address will be used to send future recredentialing information, so please make sure it is current**
- Date of birth – required to begin the credentialing process
- Specialty (i.e. General Dentist, Pediatric Dentist, Oral Surgeon, etc.)
- State License section must be completed or a copy of the license provided. Providing a copy of the license will expedite the credentialing process:
- State DEA issued by Commonwealth of Massachusetts – enclose a copy or provide a disclosure for the prescribing provider (as seen in question 13 of the questionnaire).
- Complete DEA section. A DEA is required for each state where you practice. A disclosure is required if you do not hold a DEA.
- Individual NPI number
- Group NPI if W-9 Type is Corporation, LLC, or Partnership (exception: sole proprietor's with an LLC)
- Location Name, address, city, state, zip, phone, fax, email address. If additional locations need to be submitted, please attach a separate list of locations with the pertinent information.
- Credentialing correspondence contact, email address, phone and address, city, state, zip.
- American Board Certification – if you hold board certifications, you must list them.
- Privilege Information – you must identify hospital(s) at which you have admitting privileges.
- Employment History section of application or curriculum vitae—5 year history required in month and year format. An explanation of gaps within the last 5 years that are greater than 6 months is required. **Start date at primary location is required.**
- Professional School/ Residency Section – list all institutions and training with the month and year of attendance.
- Liability Insurance Binder - must not expire within 60 days and must comply with plan limits
- Attestation Questions (yes/no section) completed.
- If "Yes" to any attestation questions (1-12) please enclose a separate disclosure explanation page,
- If "No" to questions 13-16, please enclose a separate disclosure explanation page.
- Signed Application - must be hand written, no stamps. Date must be less than 120 days old.

Fax – (617) 886-1414

*****INCOMPLETE APPLICATIONS WILL DELAY THE CREDENTIALING PROCESS*****

1. Please print or type **ALL** responses.
2. If you need additional space to complete a section, please attach additional sheets.
3. If you answer "yes" to questions (1-14) on the Questionnaire Section and "no" to questions (17-18), you **MUST** attach a detailed explanation.
4. **Incomplete applications will not be accepted. Every field must be completed. If an item is not applicable, please indicate "N/A."**
5. **Please complete all sections with additional focus on those sections or questions with an asterisk (*).**

PLEASE REMEMBER:
PROVIDER CANNOT BEGIN TO TREAT MEMBERS UNTIL A WELCOME LETTER FROM DELTA DENTAL OF MASSACHUSETTS IS RECEIVED

Delta Dental of Massachusetts Credentialing Process

Credentialing is the process of verifying credentials (i.e. training, licensing, and hospital affiliations) of potential providers by primary sources. Delta Dental of Massachusetts takes pride in its network of providers and is proud to say that all providers are credentialed following the guidelines of the National Committee for Quality Assurance (NCQA) to ensure our members that they are receiving the best quality care possible. Using NCQA guidelines for credentialing ensures an organization that the providers affiliated with their panel are the best in the dental field.

PLEASE Check if this is applicable:

☐ New Provider, Existing Location

Please add _____ to current contract under _____
(Provider Name) (Entity Name)
with Tax ID# _____.

Available Plans PLEASE Check all that apply:

Please Note: A contract is required for of the plans.

☐ Delta Dental Premier ☐ Delta Dental EPO ☐ Delta Dental PPO
☐ DeltaCare ☐ DeltaCare Specialty ☐ Massachusetts Public Employees

PROVIDER APPLICATION GENERAL INFORMATION			
*Last Name	*First Name		Middle Initial
*Degree	* Provider Social Security Number	*Date of Birth (MM/DD/YYYY)	*Provider Personal E-mail Address
☐ Male ☐ Female Provider Gender	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ White Provider Race/Ethnicity ☐ Other		*Specialty
*Languages spoken by the provider (check all that apply) ☐ English ☐ Spanish ☐ Arabic ☐ Chinese ☐ French ☐ German ☐ Hmong ☐ Hindi ☐ Laotian ☐ Philippine ☐ Vietnamese ☐Other _____			
Please list Dental, Medical and Anesthesia licenses for all states you currently hold or previously held a license.			
*License Type	*License Number		*License State
License Type	License Number		License State
If you do not hold a DEA license, please provide an explanation as to why and the name of the provider who will prescribe on your behalf, should a patient require medications. This can be provided on the questionnaire page. *DEA Number _____ Expiration Date _____ **Note: A DEA license is required for each state you practice in.**			

If you do not hold a State Drug License, please provide an explanation as to why and the name of the provider who will prescribe on your behalf, should a patient require medications.

*State Drug Number _____ Expiration Date _____ **Note: A copy of your State Drug License is required.**

INDIVIDUAL NPI NUMBER

*Individual NPI Number	*Taxonomy Code

PROFESSIONAL EMPLOYMENT HISTORY (READ CAREFULLY)

Chronologically list all present and previous work history related to your professional employment within the past five (5) years (if you graduated less than five (5) years ago work history should be provided starting with your graduation date). All dates must be in **Month and year format**.
Please provide a written explanation of any gaps greater than 6 Months.

***What was your start date at the location you are being credentialed for: _____ / _____ (month/ year)**

Hire Date (MM/YYYY)	Termination Date (MM/YYYY)	Employer	Location Address	Reason for Leaving

PROFESSIONAL SCHOOL/ RESIDENCY

Professional School Name	City/State	Degree(s)	Date Received

Post Graduate Education- Name	City / State	Specialty	Beginning Date	Completion Date
Post Graduate Education- Name	City / State	Specialty	Beginning Date	Completion Date

AMERICAN SPECIALTY BOARD CERTIFICATION

Specialty Board(s) by which you are certified Name	Date Certified	Expiration Date	Recertification Date

HOSPITAL PRIVILEGES

List all Hospitals at which you have admitting privileges:

Hospital Name	Address	City	State
Hospital Name	Address	City	State

PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE

I am currently covered by the Federal Tort Claims Act**?** □ **Yes** □ **No** If No, complete the section below with current malpractice carrier information. If Yes please complete the section below with Qualifying Entity information for a Community Health Center.

Please Note: A copy of the Insurance Declaration Page is required when submitting your application.

Name of current Carrier		Mailing Address		
Phone #	Fax #	Policy #	Effective Date	Expiration Date
Amounts of Coverage: Occurrence/Claim $_____		Aggregate $_____		
Name of Community Health Center (Please attach a copy of the Notice of Deeming Action)				
Effective Date		Expiration Date		
Coverage Limits				

OTHER NPI INFORMATION

□Please check box if Sole Proprietor is indicated on your W9. ALL providers MUST complete NPI information.

GROUP /ORGANIZATION NPI INFORMATION (REQUIRED unless Sole Proprietor is indicated on your W9)

Group NPI Number	Taxonomy Code

SUB-PART NPI INFORMATION (Not required)

Sub Part NPI Number	Taxonomy Code

PRIMARY SERVICE OFFICE INFORMATION

*Primary Office Name	*Office Contact	*Office Phone Number	*Office Fax Number
*Primary Office Address		*Office Email Address	
*City	*State	*Zip Code	*County

Patient Type (check one) □ Adults Only □ Children Only □ Adults & Children

*Minimum Age _____ Maximum Age _____

Office Hours Primary Location	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

*In the event of an emergency, do you have coverage after normal business hours or provide emergency contact information on your office phone or have any other protocol? □ Yes □ No If yes, Please list your contact information: _____

*Languages spoken at office (check all that apply)

□ English □ Spanish □ Arabic □ Chinese □ French □ German □ Hmong □ Hindi □ Laotian □ Philippine □ Vietnamese □Other _____

*Are you accepting new patients at this office?	□ Yes □ No
*Is this office convenient to public transportation?	□ Yes □ No
*Does your practice treat adults with disabilities at this location?	□ Yes □ No
*Does your practice treat children with disabilities at this location?	□ Yes □ No
*Is your office handicapped/wheelchair accessible?	□ Yes □ No
*Is your entry way handicapped/wheelchair accessible?	□ Yes □ No
*Is your waiting room handicapped/wheelchair accessible?	□ Yes □ No
*Are your bathrooms handicapped/wheelchair accessible?	□ Yes □ No
*Are your treatment room's handicapped/wheelchair accessible?	□ Yes □ No

BILLING INFORMATION			
*Federal Tax Identification Name (Name as it appears on Line 1 of W9)		*Federal Tax Identification Number	
*Billing Office Address	*City	*State	*Zip Code
*Billing Office Contact Name / Title	*Telephone Number	*Fax Number	

PLEASE NOTE: If additional locations need to be submitted, please attach a separate list of locations with the pertinent information.

CREDENTIALING CORRESPONDENCE INFORMATION (address where credentialing information will be sent)			
*Credentialing Correspondence Office Name	*Credentialing Contact Name	*Credentialing Telephone Number	*Credentialing Fax Number
*Correspondence Address		*Credentialing Correspondence E-mail Address	
*City	*State	*Zip Code	

QUESTIONNAIRE

Please read each of the following questions carefully.

YES	NO		
____	____	1.	Has your Professional License been limited, suspended, denied, revoked, restricted, subject to probationary conditions, or have proceedings been instituted against you?
____	____	2.	Have you allowed your Professional License to expire in a state you no longer practice in? If yes, what state? _____
____	____	3.	Other than allowing a license to expire because you no longer practice in a state, have you voluntarily relinquished, reduced, restricted, or otherwise limited your Professional License in any jurisdiction?
____	____	4.	Have you been reprimanded or disciplined by any State or Commonwealth Department of Regulation and Licensure of any Professional Examining Board?
____	____	5.	Have you ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, Office of Inspector General (OIG) or any public program or is any such action pending or under review?
____	____	6.	Do you have a history of felony convictions?
____	____	7.	Has your participation with a managed care organization, other health care organization, or hospital privileges been suspended, limited, or terminated?
____	____	8.	Have you had a judgment made against you for alleged malpractice, negligence, or related matters? Are any cases pending?
____	____	9.	Have you had any judgments made against you in a professional liability case or has your liability insurer placed any conditions or restrictions on your coverage or ability to attain coverage?
____	____	10.	Have any litigation settlements been made on your behalf?
____	____	11.	Are you currently using illegal drugs?
____	____	12.	Are you, or have you been, under the treatment for the use of narcotics, barbiturates, alcohol, or other drugs?
____	____	13.	Do you presently have any physical or mental conditions that would adversely affect your ability to provide high quality professional services? Are there any accommodations that need to be considered? Please list accommodations in a disclosure.
____	____	14.	Has your Drug Enforcement Agency (DEA) registration been denied, revoked, suspended, or not renewed?
____	____	15.	Do you currently have an active DEA in the state(s) in which you practice? If not: ☐ I refer my patients to their Primary Care Physician or Urgent Care/Emergency Room ☐ _____ will write any prescriptions needed for my patients Prescribing Provider's DEA Number _____
____	____	16.	Do you currently have an active State Drug License in the state(s) in which you practice? If not: ☐ I refer my patients to their Primary Care Physician or Urgent Care/Emergency Room ☐ _____ will write any prescriptions needed for my patients Prescribing Provider's State Drug License Number _____

Dentist Name: (Please Print) _____

QUESTIONNAIRE PAGE 2

____ ____ 17. Do you follow the current recommendations of the American Dental Association and the Centers for Disease Control regarding infection control?

____ ____ 18. Do you comply with the Occupational Exposure to Blood borne Pathogens Standards of OSHA regulations?

Dentist Name: (Please Print) _____

CERTIFICATION, STATEMENTS, AND SIGNATURE

I hereby acknowledge that the information provided in this application is material to the determination by **Delta Dental of Massachusetts** whether or not to execute an agreement with me. I hereby represent and warrant that all information provided herein is true, correct and complete to the best of my knowledge, and I agree to notify **Delta Dental of Massachusetts** in the event an error is discovered or when new events occur which alter the validity of any response herein. I hereby authorize **Delta Dental of Massachusetts** to consult with individuals or institutions with which I have been associated and with others, including but not limited to past and present malpractice carriers, educational institutions, and state licensing boards, who may have information bearing on my professional competence, character and ethical qualifications and authorize the release of any such written or oral verification as needed by Delta Dental of Massachusetts. I hereby release from liability for any such entity, institution, or organization that provides information as part of the application process.

I certify that:

* All parties of material interest have been identified and include no persons or entities with a potential for profit from self-referral,
* All services are provided by and under the "on Premise" supervision of a licensed dentist,
* The above information is complete, correct and true to the best of my knowledge,
* My malpractice information is current at the time of application and the limits are at or exceed the minimum amounts required by the Plan and Delta Dental of Massachusetts.

Individual Provider Participation Attestation
Attestation to confirm that you have agreed to become a Participation Provider/ Provider Dentist in the Delta Dental of Massachusetts provider network, by means of your or your office's Provider Agreement with Delta Dental of Massachusetts to render services to Members pursuant to the Agreement with Delta Dental of Massachusetts.

Power of Attorney
The undersigned does hereby constitute and appoint each owner, member and partner of the entity set forth in the space designated for "Entity Name" on Page 3 of this document ("Entity"), its true and lawful attorney-in-fact, in undersigned's name, place, and stead, to execute, acknowledge, sign and deliver any and all contracts, documents, and writings on undersigned's behalf in connection with arrangements with Delta Dental of Massachusetts for the provision of dental services. And the undersigned grants said agent full power and authority to do, take, and perform all and every act and thing whatsoever requisite, proper, or necessary to be done, in the exercise of any of the rights and powers herein granted, as fully to all intents and purposes as undersigned might or could do if personally present, with full power of substitution or revocation, hereby ratifying and confirming all that said agent, or his/her/its substitute or substitutes, shall lawfully do or cause to be done by virtue of this power of attorney and the rights and powers herein granted.

Signed by: _____ Date: _____
Principal

Please print name: _____

All applications are subject to review and approval by DELTA DENTAL OF MASSACHUSETTS.

All information contained in a credentialing file will be held in strict confidence, and available for review by only duly authorized employees of Delta Dental of Massachusetts, and/or third party review organizations (i.e. NCQA, etc.). Practitioner has the right to obtain a copy of their credentialing file, by submitting a written, signed request to the Supervisor of Credentialing at the corporate headquarters for. Any corrections, additions, or clarifications to these files must be submitted in writing to the Supervisor of Credentialing within 30 days of the original submission. This information will be added to the provider application and considered in the credentialing decision. The practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application via phone, fax, or mail. If the Credentialing Committee recommends the acceptance of an application with restrictions, denial of an application, or discipline or termination of a practitioner, written notification will be issued within 30 days of that decision. The practitioner then has 30 days from the date of the notice to submit a written appeal of that decision. Appeals should be addressed to the Credentialing Committee, sent to Delta Dental of Massachusetts's corporate address.

In the event that a dentist's application for participation is rejected or limited for reasons pertaining to the applicant's professional conduct or competence, Delta Dental of Massachusetts is required to submit a report to the National Practitioner Data Bank and/or the state licensing board as required by law.