BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Dental Enrollment Application

We cannot process this credentialing application until you complete it in full.

Please maintain a copy of this application for your records.

Your individual dentist contract is portable, and we will apply it to all current locations where you are practicing as identified in this application.

The information contained in this application will be used by the contracting entity of each participation agreement and for each network you wish to participate in, including those of affiliates.

The Dental Enrollment Application is complete when:

- You have signed and dated it
- You have attached current copies of:
  - Dental license (include copies of **every** state in which you are licensed)
  - Federal DEA registration for **every entity** in which the DDS is prescribing controlled substances (or documentation that DEA registration is pending)
  - American Board/Specialty Certificate (if applicable)
  - Professional Liability Insurance Declaration page for each state in which you practice, showing policy limits, dentist's name, policy number, effective and expiration dates. If the expiration date is within weeks of this application, submit updated documentation.
  - Authorization to Bill
- For multiple practice locations, attach a separate spreadsheet with practice information.
- A signed contract signature page for the Participating Dental Network. Request a copy.

Email the completed application and required documentation to Provider.Blue.Enroll@bcbssc.com or fax at 803-870-8919.

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, we will notify and allow you an opportunity to correct erroneous information submitted by another party within 30 days of submitting your application. This includes information submitted by an outside primary source, such as a professional insurance carrier, state-licensed board and/or the National Practitioner Data Bank and the Healthcare Integrity Protection Data Bank.

Confidentiality Statement

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

Revised Nov. 5, 2021

Demographics **State Dental License Number:** _____

Name: _____ ☐ DMD ☐ DDS ☐ Other: _____

SSN: _____ Birth Date: _____ ☐ Owner ☐ Partner ☐ Associate

Individual NPI: _____ Gender: ☐ Male ☐ Female

Federal DEA: Do you currently hold a federal DEA registration in each state you prescribe controlled substances?

☐ Yes (Submit copy) ☐ No

If DEA application has been submitted and is pending, DDS will not write prescriptions until DEA is finalized.

Languages Spoken (other than English): _____ , _____ , _____ DDS' Initials: _____

Primary Practice Location – If more than one location, attach a separate sheet with this information.

Primary Office: _____

Group Name and Clinic Name (if different)

Street Address: _____

City: _____ State: _____ ZIP: _____ County: _____

Office Phone Number: _____ Emergency/After Hours Number: _____

Fax Number: _____ Handicap Accessible? ☐ Yes ☐ No

Tax ID: _____ Corporate NPI: _____

Office Manager/Contact: _____ Office Email: _____

Office Hours:	**Mon.**	**Tues.**	**Wed.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**
Open:	____	____	____	____	____	____	____
Close:	____	____	____	____	____	____	____

☐ Clinic Hours ☐ Provider Hours

Are you accepting new patients? ☐ Yes ☐ No

Are there any age limitations? ☐ Yes ☐ No Min. Age: ____ Max. Age: ____

Are there any gender restrictions? ☐ Males only ☐ Females only ☐ Both, no restrictions

Please describe any other patient limitations: _____

Billing Information (If different from the mailing address)

Billing Name: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____ County: _____

Office Manager/Contact: _____ Office Email: _____

Billing Phone Number: _____ Billing Tax ID: _____

General Dentistry Education

Institution Name: _____

Graduation Date (MM/YY): _____ Degree: _____

Specialty Education

Institution Name: _____

Specialty: _____ Graduation Date (MM/YY): _____ Degree: _____

For this specialty, I am:

☐ Educationally qualified (Attach a copy of certificate showing institution name, graduation year, and specialty.)

☐ American Board Certified* (Attach a copy of certificate from the American Board.)

* Certification Date: _____ Expiration Date: _____

Professional Liability Insurance for each entity in which you practice – Complete this information or attach a copy.

Carrier: _____ Policy Limits: _____ Policy Number: _____

Effective Date: _____ Expiration Date: _____

DISCLOSURE QUESTIONS

Please complete the malpractice or board action addendum if any "yes" is selected for questions 1 – 10.

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 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, censored 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 a minor traffic violation) 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, misconduct, or 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/$3 million?

DISCLOSURE QUESTIONS & 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 so that it remains so while my application is being processed. I certify that my office protocols for infection control are in compliance with current CDC/OSHA guidelines. I agree to update changes in malpractice coverage, including changes in the insurance carrier or policy number, as they occur.

By completing this application to become a participating provider, I fully understand that any significant misstatement in, or omission from, my application to become a participating provider may constitute cause for denial of my application or the subsequent termination of my participating provider contract if my application is accepted. I understand and agree that this consent is irrevocable for any period during which I am a participating provider. Acceptance in any individual network is 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/Healthcare Integrity and Protection Data Bank administered by the U.S. Department of Health and Human Services.

I authorize release of information to complete this application.

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 BlueCross 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 provider.

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: _____ Name: _____ Date: _____

MALPRACTICE OR BOARD ACTION

Please complete this addendum only if you answered "yes" to disclosure questions 1 – 10. Attach a separate sheet, if needed.

Malpractice Claim(s)

Occurrence Date: _____ Settlement Amount: _____

Name of Insurance Carrier: _____

Insurance Carrier Address: _____

City: _____ State: _____ ZIP: _____ County: _____

Status of Claim: _____ Date Claim Resolved: _____

Details of Allegations: _____
_____
_____
_____

Board Action(s)

Occurrence Date: _____ Date of Satisfaction/Closure: _____ Amount of Fine Paid: _____

Name of Insurance Carrier: _____

Details of Action (conditions, limitations, etc.)—Attach a copy of Board Action/Corrective Action:
_____
_____
_____
_____

Employment History – Chronological listing must include the month and year for each entry of employment history for the most recent five years. List all armed service, public health, education, business, etc. Leave no gaps in chronology.

Date (Month & Year)	Facility & Address	Phone Number & Tax ID	Reason for Leaving
_____ - _____			
_____ - _____			
_____ - _____			

Primary Admitting Facility

Facility Name: _____ Street Address: _____

City: _____ State: _____ ZIP: _____

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.