Guardian

Provider Credentialing Application

General Information

Full Name: _____ _____ _____
First *Middle* *Last* *Suffix* *Degree*

Provider Email: _____ Fax: _____

Gender: ☐ Female ☐ Male ☐ Non-Binary Social Security Number: _____-_____-_____

Birth Date: _____ NPI-1: _____

Home address: Please complete in full.

Street address: _____

_____ _____ _____
City *State* *Zip*

Please include any other name(s) for which you have been known:

Full Name(s): _____From ____ /_____ To ____/_____
(MM/YYYY) *(MM/YYYY)*

Dental License: Please provide current and expired dental license details with issue and expiration dates in MM/DD/YYYY format.

Number: _____ Status: _____

State: _____ Issue Date: ____/____/_____ Expiration Date: ____/____/_____

Number: _____ Status: _____

State: _____ Issue Date: ____/____/_____ Expiration Date: ____/____/_____

DEA Certification(s): Please provide DEA certification details with issue and expiration dates in MM/DD/YYYY format.

DEA Number: _____ Status: _____

State: _____ Issue Date: ____/____/_____ Expiration Date: ____/____/_____

DEA Number: _____ Status: _____

State: _____ Issue Date: ____/____/_____ Expiration Date: ____/____/_____

Controlled Substance Certificate: Please provide details of CSC registrations.

Number: _____ Status: _____

State: _____ Issue Date: ____/____/_____ Expiration Date: ____/____/_____

Number: _____ Status: _____

State: _____ Issue Date: ____/____/_____ Expiration Date: ____/____/_____

Anesthesia Permit: Please provide details of Anesthesia Permits.

Number: _____ Status: _____

State: _____ Issue Date: ____/____/_____ Expiration Date: ____/____/_____

Additional or Other Certification(s): Please provide details of any other certifications.

Certificate Type: _____ Certificate number: _____

State: _____ Issue Date: ____/____/_____ Expiration Date: ____/____/_____

Certificate Type: _____ Certificate number: _____

State: _____ Issue Date: ____/____/_____ Expiration Date: ____/____/_____

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Provider Full Name: _____ NPI-1: _____

Primary Service Location: Please provide full details for your primary location. If practicing at multiple locations, please list any additional locations on a separate page.

Practice Type: ☐ Family Planning ☐ FQHC ☐ Indian Health Clinic ☐ Mobile ☐ Ryan White ☐ Teledentistry

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Tax ID: _____ Phone: _____ Fax: _____

Credentialing Contact: _____

Credentialing Phone: _____ Credentialing Email _____

Group NPI-2: _____ Are Credit Cards Accepted? ☐ Yes ☐ No

Emergency & Patient Access Services: Please provide practice capabilities.

Age of patients accepted From _____ To _____ Are emergency services available 24 hours per day? ☐ Yes ☐ No

Method of Access: ☐ Answering Service ☐ Urgent Care ☐ Emergency Room ☐ Emergency Phone# _____

Accepts patients with disabilities ☐ Yes ☐ No Teletype available ☐ Yes ☐ No

ADA compliant accessible office ☐ Yes ☐ No Accessible parking ☐ Yes ☐ No

CPR certified staff ☐ Yes ☐ No Accepts new patients ☐ Yes ☐ No

Endodontics: ☐ Anterior root canal treatment ☐ Bicuspid root canal treatment ☐ Molar root canal treatment

Periodontics: ☐ Surgical periodontal services

Oral Surgery: ☐ Erupted tooth surgical removal ☐ Impaction tooth removal

Restorative: ☐ Amalgam restorations ☐ Scaling and root planing ☐ Composite restorations

Pediatric Dentistry: ☐ Routine care <8 years old ☐ Routine care> 8 years old

Please indicate which services are offered at this location:

☐ Nitrous Oxide ☐ General Anesthesia ☐ IV sedation ☐ Oral sedation ☐ Panoramic X-ray ☐ Intraoral X-ray

☐ Electronic Claim Submission ☐ Digital radiograph submission

Sterilization method: ☐ Autoclave ☐ Chemclave ☐ Other

Please indicate all languages spoken at this location.

☐ English ☐ _____ ☐ _____ ☐ _____

Please provide the hours of operation at this location:

☐ Monday _____ to _____ ☐ Tuesday _____ to _____ ☐ Wednesday _____ to _____

☐ Thursday _____ to _____ ☐ Friday _____ to _____ ☐ Saturday _____ to _____

☐ Sunday _____ to _____

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Provider Full Name: _____ NPI-1: _____

Correspondence Address: Please indicate the address to which you would like all written correspondence sent.

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Manager: _____ Phone: _____

Office Manager's email address: _____

Billing Address: Please indicate the address to which you would like all payment remittances sent.

☐ Same as correspondence address

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Billing Manager: _____ Phone: _____

Billing Manager's email address: _____

Provider Specialty: Please indicate specialty, if other than General Dentist.

Primary specialty: _____

Board Certification: Please complete all applicable fields. ☐ Not Applicable

Name of Board: _____

Board Status: _____ Lifetime Certified: ☐ Yes ☐ No

Certification Date: _____ Expiration Date: _____

Education: Please complete all relevant fields.

Education Type: ☐ Undergraduate ☐ Graduate ☐ Post graduate Degree Earned: _____

Institution Name: _____ From ____ /_____ To ____ /_____
(MM/YYYY) *(MM/YYYY)*

Address: _____

City: _____ State: _____ Zip: _____ Country (if non-US) _____

Education Type: ☐ Undergraduate ☐ Graduate ☐ Post graduate Degree Earned: _____

Institution Name: _____ From ____ /_____ To ____ /_____
(MM/YYYY) *(MM/YYYY)*

Address: _____

City: _____ State: _____ Zip: _____ Country (if non-US) _____

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Provider Full Name: _____ NPI-1: _____

Work History

Beginning with the most current and in chronological order, please list all places of clinical practice and/or employment over the last 5 years since completion of training. In addition, please explain any gaps greater than 6 months or more on a separate piece of paper unless otherwise mandated by your state. If currently employed, please leave 'to' date blank and check box instead.

Employer: _____ Date (MM/YYYY) From ____ /_____ to ____ /_____ Currently Employed: ☐

Address: _____ Phone: _____

Employer: _____ Date (MM/YYYY) From ____ /_____ to ____ /_____ Currently Employed: ☐

Address: _____ Phone: _____

Employer: _____ Date (MM/YYYY) From ____ /_____ to ____ /_____ Currently Employed: ☐

Address: _____ Phone: _____

Employer: _____ Date (MM/YYYY) From ____ /_____ to ____ /_____ Currently Employed: ☐

Address: _____ Phone: _____

Employer: _____ Date (MM/YYYY) From ____ /_____ to ____ /_____ Currently Employed: ☐

Address: _____ Phone: _____

Work Gap Explanation(s):

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Provider Full Name: _____ NPI-1: _____

Attestation Questions

Please answer each of the following questions. Any questions answered adversely will require a detailed explanation.

1. Have any of the following ever been or are currently under investigation or restriction? (e.g., denied, revoked, suspended, probated, not renewed)?
    a. License to practice in any jurisdiction ☐ Yes ☐ No
    b. Board certification ☐ Yes ☐ No
    c. Federal DEA Registration ☐ Yes ☐ No
    d. State Controlled Substance Registration ☐ Yes ☐ No
    e. Clinical Privileges ☐ Yes ☐ No
    f. Participation in the Medical/Medicaid programs ☐ Yes ☐ No
    g. Membership in other hospital/healthcare facility medical/ professional staff ☐ Yes ☐ No
    h. Professional society membership ☐ Yes ☐ No
2. Have you ever been convicted of, or have any charges pending against you, related to a felony or misdemeanor, other than minor traffic offenses? ☐ Yes ☐ No
3. Has any professional liability coverage ever been denied, cancelled, reduced, limited, terminated, or not renewed due to action taken by an insurance carrier? ☐ Yes ☐ No
4. Are you requesting any privileges not covered by your professional liability insurance? ☐ Yes ☐ No
5. Have any professional liability suits filed resulted in a judgement against you or been terminated pursuant to a settlement in which you have paid damages to a plaintiff, with or without admitting liability? ☐ Yes ☐ No
6. Have you ever settled any professional liability claim against you prior to a suit and admitted liability as part of such a settlement? ☐ Yes ☐ No
7. Are you now or have you ever engaged in the illegal use of controlled substances? ☐ Yes ☐ No
8. Are you currently or have you ever participated in a supervised rehabilitation program or professional assistance program as a patient? ☐ Yes ☐ No
9. Within the last 10 years, has a suit been filed against an institution or entity based on alleged negligent medical acts or omissions by you (even if dismissed or dropped) other than identified above (e.g., a suite against a teaching hospital, university, governmental entity or other employers)? ☐ Yes ☐ No
10. In the last 10 years, has a settlement been made by an institution based upon alleged negligent medical acts or omissions by you? ☐ Yes ☐ No
11. Are you currently, or have you ever been, the subject of an individual focused review by a healthcare facility's Quality Assurance, Utilization Review, Risk Management, Peer Review or similar monitoring committee? ☐ Yes ☐ No
12. Has any professional review organization under contract with Medicare or Medicaid ever made an adverse quality determination concerning your treatment rendered to a patient? ☐ Yes ☐ No
13. Do you have a condition that could compromise your ability to perform any of the mental and physical functions related to the specific clinical privileges you are requesting? ☐ Yes ☐ No
14. Within the last 5 years, have you had any gaps of 6 months or greater, where you did not work as a practitioner in this current discipline? *If "Yes", please explain the reason(s) for any gap(s) on a separate sheet.* ☐ Yes ☐ No

Attestation & Credentials Release of Verification

I attest that all information provided in this Application is true and complete to the best of my knowledge and belief. I will notify The Guardian Life Insurance Company of America and/or its affiliates as well as their agents ("Guardian"), through designated contact person/method, within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of membership and/or privileges or affiliation by Guardian, and must be submitted on-line or in writing, and must be dated and signed by me.

I, the undersigned Provider, authorize Guardian, to whom information on this Application may be released on an ongoing and continuing basis, as well as anyone with whom it may enter into a contract with (collectively, "Representatives") to obtain information from others, including but not limited to: state licensing authorities, certification boards, National Practitioner Data Bank (NPDB), professional liability and malpractice insurance carriers (including claim histories and loss reports), hospitals, substance abuse programs, members of medical or other professional staffs, dental administrators, hospital administrators and health-care-related employers that may be necessary to evaluate my qualifications, including without limitation, my professional competence and conduct, information about disciplinary actions and information that might otherwise be considered confidential or privileged (collectively, "Credentialing Information"). I authorize Guardian to request and receive verification of Credential Information and authorize Guardian to monitor my credentials on an ongoing and continuing basis. I understand that I have the burden of providing adequate and accurate information to demonstrate my qualifications and that statements written on this application will be considered statements made by me, even if prepared by another, including but not limited to an employee, agent or representative.

I attest that the information contained in this application is correct and complete and understand that any misstatement or omission on this application may constitute grounds for rejection of my application or dismissal as Participating Provider with Guardian's or its client-sponsored networks. I understand that it is my ongoing obligation to immediately notify Guardian: (i) of any changes to the information provided (including but not limited to changes to professional liability insurance, malpractice status, physical or mental condition, or state dental license status), or (ii) if I have reason to believe or become aware that any information provided is inaccurate or inadequate. I understand that if Guardian denies my application or otherwise takes action that is adverse to my request for participation, Guardian may be obligated, under applicable law, to report such action to the NPDB and/or other licensing or accreditation agencies. I authorize Guardian to disclose any and all Credentialing Information to its members, payor clients or other entities who may lease a Provider Network from Guardian, subject to applicable law, rules and regulations. I understand that credentialing requirements may vary from state to state and additional information may be required. I release Guardian from any and all liability for acts performed in good faith and without malice in obtaining and verifying the information collected and evaluating my application. I agree that a digital image of this document, as executed, shall be considered as a true and correct original and admissible as best evidence to the extent permitted by a court with proper jurisdiction.

Print Provider's Name: _____

Provider's Original Signature: _____

Note: Stamped signatures will not be accepted

Date: _____/_____/_____