



EMI HEALTH DENTAL CREDENTIALING FORM

EMI Health • 852 East Arrowhead Lane • Murray, Utah 84107-5298 • 801-262-7975

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER	GENDER
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PRACTICE STATUS: INDIVIDUAL PARTNER GROUP OTHER: _____

PRACTICE OR GROUP NAME: _____

PRINCIPAL OFFICE LOCATION	SECONDARY OFFICE LOCATION
STREET _____	STREET _____
CITY _____ STATE _____ ZIP _____ COUNTY _____	CITY _____ STATE _____ ZIP _____ COUNTY _____
TELEPHONE _____ TAX ID NUMBER _____	TELEPHONE _____ TAX ID NUMBER _____
FAX _____ EMAIL ADDRESS _____	FAX _____ EMAIL ADDRESS _____

INDIVIDUAL NPI: _____	GROUP NPI: _____ NPI USED FOR BILLING: <input type="checkbox"/> YES <input type="checkbox"/> NO
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BILLING ADDRESS (if different than above)	CORRESPONDENCE ADDRESS (if different than above)
PAY TO NAME _____	CORRESPONDENCE NAME _____
ADDRESS _____	ADDRESS _____
CITY _____ STATE _____ ZIP _____ COUNTY _____	CITY _____ STATE _____ ZIP _____ COUNTY _____
TELEPHONE _____ CONTACT NAME _____	TELEPHONE _____ CONTACT NAME _____

DENTIST'S DATE OF BIRTH _____	OFFICE MANAGER'S NAME _____
PRIMARY STATE OF LICENSURE / LICENSE # (PLEASE ENCLOSE COPY) _____	SECONDARY STATE OF LICENSURE / LICENSE # (PLEASE ENCLOSE COPY) _____
DEA NUMBER (PLEASE ENCLOSE COPY) _____	LIST LANGUAGES IN WHICH YOU ARE FLUENT _____

<input type="checkbox"/> Endodontics	<input type="checkbox"/> Orthodontics	<input type="checkbox"/> Prosthodontics
<input type="checkbox"/> General Dentistry	<input type="checkbox"/> Pediatric Dentistry	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Oral & Maxofacial Surgery	<input type="checkbox"/> Periodontics	
Please list any other services you provide: _____		

For each specialty indicated, clarify that you are board certified or eligible to take boards and specify the name of the certifying board.

PRIMARY SPECIALTY	Certified _____	Eligible _____	Certifying Board _____
SECONDARY SPECIALTY	Certified _____	Eligible _____	Certifying Board _____

PRACTICE

SPECIALTY

DO NOT FILL OUT DENTAL TRAINING SECTION WHEN RE-CREDENTIALING

Medical / Dental School	Location	Year Graduated
Internship	Location	Dates: From: To:
Residency	Location	Dates: From: To:
If Applicable: Foreign Dental Grad. Number:		

Liability Carrier	Policy Number
Amount of Coverage per Occurrence	Aggregate
Malpractice Action: Number of Pending Claims: _____ (if none, please write "none.") Number of prior malpractice judgments or settlements within the last ten years: _____ (if none, please write "none.")	
For each malpractice action, please attach an explanation to this application.	

Please submit the following with your application:

- 1. Signed contract (not applicable if re-credentialing)
- 2. Proof of malpractice coverage (the policy face sheet or certificate of insurance, with effective dates)
- 3. A copy of your current state license(s)
- 4. A copy of your DEA license
- 5. Completed W-9 tax form
- 6. Release of Information Authorization
- 7. Copy of Board Certification / Education Certificates (not applicable if re-credentialing)
- 8. Additional mailing, billing, or office addresses
- 9. Any explanations requested elsewhere in this application
- 10. Any other information that you feel would be beneficial

Do you have other partners / associates in your practice? Yes No

Do you use dental assistants and / or hygienists? Yes No
(If yes, please attach names and license numbers for each.)

Have you been subject to any of the following:

Professional liability insurance cancellation in the past five years? Yes No

State licensing investigations or actions? Yes No

Conviction of a felony, fraud, moral, or ethical crime? Yes No

DEA licensing investigations or actions? Yes No

Chronic illness or physical defect that would impair your ability to practice your specialty? Yes No

Ownership in any facility or joint ownership of dental services or equipment with a facility to which you might refer patients? Yes No

Please attach an explanation of any questions answered "yes."

Are you routinely available for patient care at least four full days per week? Yes No

What are your office hours? _____

Do you offer emergency appointments? Yes No

What, if any, limitations do you have on the age range of your patients? _____

Approximately how many patients do you see per day, when in your office? _____

What, if any, limitations do you have on accepting new patients? _____

Briefly describe your practice: _____

All information is complete and accurate to the best of my knowledge. I understand that this application does not entitle me to continued participation with EMI Health. I authorize EMI Health to consult with, and inspect all documents from individuals and organizations having information bearing on my qualifications. I agree that EMI Health, its representatives, and any individuals or entities providing information to EMI Health in good faith pursuant to this release shall not be liable for any act or omission related to the evaluation or verification of information in this application. I further agree to notify EMI Health of any change to the information requested by this application.

Signature of Responsible Party

Date



PLEASE NOTE THAT THIS INFORMATION WILL BE TREATED AS CONFIDENTIAL