



Application to Join Our Dental Networks

Florida Combined Life
Dental Division
P.O. Box 45132
Jacksonville, FL 32232-9902

PERSONAL INFORMATION			
Dentist's: Last Name _____ First _____ MI: ____ Suffix: _____ Degree: _____			
Date of Birth: ____/____/____ Month Day Year	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	License#: _____ State of License: _____ Expiration Date: _____	DEA Number: Specialty:
Social Security Number:	Dentist's Individual Type 1 NPI:		
Specialty Board Certificate Status <input type="checkbox"/> No <input type="checkbox"/> Certified <input type="checkbox"/> Eligible <input type="checkbox"/> N/A		Board Certification (if applicable) Effective and Expiration Dates _____ to _____	
Education: General Practice	School:	Location:	Mo/Yr. Graduated /
Education: Specialty Training	School:	Location:	Mo/Yr. Graduated /
OFFICE AND BILLING INFORMATION			
Practice Name (as shown on W-9)			
Practice TIN:	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor		
Group Name (if applicable)			
Group Type 2 NPI:	Telephone Number:	E-mail Address:	
	Fax Number:	Website:	
Physical Address:			
City/State/Zip Code:			
Billing Address if different than above:			
City/State/Zip Code:	Languages (including Sign Language) spoken by provider, staff or interpreter:		
Does your office have TDD service for patients with hearing impairments?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your office accessible by public transportation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your office handicapped accessible?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your office have weekend hours?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

WORK HISTORY

Beginning with your current location, please provide an up-to-date professional work history for the past five (5) years. Remember to include month and year for each entry. Please include dates and explanations for any significant gaps (more than 6 weeks) in your work history. Use an additional page if needed.

From: _____ (Month) (Year)
Name of Current Practice:
Address:
City, State, Zip Code:
Phone Number:
Name of Immediately Preceding Practice or Activity:
From: _____ To: _____ (Month) (Year) (Month) (Year)
Address:
City, State, Zip Code:
Phone Number:
Name of Immediately Preceding Practice or Activity:
From: _____ To: _____ (Month) (Year) (Month) (Year)
Address:
City, State, Zip Code:
Phone Number:
Name of Immediately Preceding Practice or Activity:
From: _____ To: _____ (Month) (Year) (Month) (Year)
Address:
City, State, Zip Code:
Phone Number:

PRACTICE HISTORY**This section must be completed by the applicant****Please complete the questions below regarding your malpractice history. For each yes answer, please attach a detailed explanation.**

1. Have there been or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has your license to practice dentistry in any jurisdiction ever been denied, limited, suspended, revoked, or otherwise conditioned?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has your membership in any local, state or national professional society or organization ever been revoked or suspended? Are revocation or suspension activities presently pending, or have been denied membership or renewal in any such society or organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has your medical membership, medical privilege, or medical staff status at any hospital been granted with limitations, suspended, revoked, not renewed, denied, or subject to probationary conditions, or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has your controlled substance registration ever been denied, revoked, suspended, reduced or not renewed: or have proceedings towards those ends ever been instituted or are presently pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you been denied membership or renewal thereof, or been subjected to disciplinary action by any dental organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you been the subject of any BCBS, Medicare, Medicaid (any state) or other dental reimbursement plan suspension or probation proceedings, or restricted from receiving payments from any BCBS, Medicare, Medicaid (any state), or other third-party programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you been the subject of any disciplinary actions by state or local dental societies, any state board of registration or examiners, or the DEA?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been convicted of a felony, or are felony proceedings or indictments presently pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever been denied professional liability insurance, or have you ever had professional liability insurance cancelled?	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH STATUS

1. Do you currently have, or have you previously had, any physical or mental health condition, including drug or alcohol dependency, that could reasonably impact your ability to practice dentistry? If yes, please attach a full explanation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you unable to perform the procedures and the essential functions of dentistry, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients? If Yes, please attach a full explanation.	<input type="checkbox"/> Yes <input type="checkbox"/> No

ORAL SURGEONS ONLY

Do you have any hospital privileges and/or affiliations? If Yes, please list all current privileges and/or affiliations:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<hr/>	
Hospital Name	
<hr/>	
City/State	
<hr/>	
Start Date	

MEDICARE PARTICIPATION Yes No**REQUIRED ATTACHMENTS FOR ALL**

Attach photocopies of:

- | | |
|--|--|
| <input type="checkbox"/> Professional Liability Insurance Certificate (current) | <input type="checkbox"/> DEA Registration |
| <input type="checkbox"/> State License (current) | <input type="checkbox"/> Specialty Board Certificate |
| <input type="checkbox"/> Permits for anesthesia (as applicable for oral surgeons). | <input type="checkbox"/> Curriculum Vitae |

Affirmation Statement

I (the “**Applicant**”) represent that the information set forth in this Dentist Application (this “**Application**”) is and shall remain true, accurate and correct in all material respects throughout the period during which Life & Specialty Ventures, LLC (LSV) evaluates my Application and, if it accepts me as a Network Dentist, in accordance with the term of the Dental Network Participation Agreement (“**Agreement**”). The Applicant acknowledges and agrees that s/he shall notify LSV in a timely manner of any material changes in the information set forth in this Application occurring during the evaluation period and, if applicable, the term of the Agreement. The Applicant acknowledges that LSV may reject this Application or terminate the Agreement if it: (1) discovers any material omission or misstatement concerning any of the information set forth in this Application or (2) it is subsequently notified of a material change in such information.

If LSV, in its sole discretion, accepts the applicant as a Network Dentist, this Application shall be attached to and incorporated into the Agreement. The Dentist acknowledges and agrees that the Agreement shall be binding upon the parties only on and after its Effective Date, which shall be the date upon which the Agreement is signed by a representative of LSV.

Consent to Release Information

All information submitted by me in this application is true to my best knowledge and belief. I understand that this application does not create any right or expectation that I will be accepted by LSV as a Network Dentist.

I authorize LSV and its Representatives to consult with persons or entities (“**Persons**”) to obtain and verify information concerning my professional competence, conduct, character, moral and ethical qualities, experience or other any other matters that LSV deems to be relevant in evaluating my Application (my “**Qualifications**”). I release LSV, such Persons and their respective Representatives from any and all liability for any and all non-malicious acts or omissions arising from or related to the provision, receipt, verification or evaluation of information pertaining to my Qualifications to become a Network Dentist.

I consent to permit Persons contacted by LSV or its Representatives to release any and all information or documents to LSV that it, in its discretion, may find relevant to an evaluation of my Qualifications, including without limitation: information or documents relating to any disciplinary action, suspension or curtailment of my license or privileges; and reports or summaries by professional liability insurance carriers relating to my insurance coverage’s and or professional liability loss experience

I acknowledge that I have the burden of demonstrating my Qualifications to serve as a Network Dentist both now and in the future. Any dispute related to this Application shall be resolved in accordance with the Dispute Resolution Procedure section of the Dental Manual and, if LSV substantially prevails in any action pursuant to that Procedure, I shall reimburse LSV for any and all expenses incurred in connection with that action, including its attorneys’ fees.

This Consent shall remain in full force and effect and may be relied on by those Persons providing information to LSV unless and until it is specifically revoked by me in writing. Any such revocation shall not apply retrospectively. A photocopy of this authorization shall be as effective as the original when presented.

Dentist:

By: _____
(Print name)

Title: _____

Signature: _____

Address: _____

Date of Signature: _____