GENERAL DENTIST

ADD ON PACKET ALL ZONES

FOR USE ONLY WITH EXISTING CENTERS

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Website: www.SavonDentalPlan.com
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Provider Credentialing Check List

PLEASE MAKE SURE THAT YOU ARE ENCLOSING ALL OF THE FOLLOWING ITEMS

[ ] The COMPLETED one (1) page PROVIDER PROFILE

[ ] PROFESSIONAL LIABILITY INSURANCE POLICY NUMBER AND EXPIRATION DATE

[ ] STATE DENTAL LICENSE NUMBER AND EXPIRATION DATE

[ ] DEA CERTIFICATE LICENSE NUMBER AND EXPIRATION DATE

***PLEASE NOTE:** Please submit separate credentialing information for each provider at your facility. Copies of this page are permissible*

Provider Profile *(A separate profile is required for each provider)*

Please type or print clearly - All information is required unless noted otherwise

What is your name?____D.D.S. or D.M.D. Date of Birth_____/_____/_______

Emergency or Cell Phone Number: (______)_______________ What is your EMAIL address?____

What Dental College did you graduate from?____In What Year?__________

What is your License Number?______________________________ State:_________ When does it expire?____/____/20______

Who is your Professional Liability Insurance Carrier?____

What is your Policy Number?____ When does your policy expire?____/____/20______

What is your D.E.A. Number?____________________________________ When does it expire?____/____/20______

Name of Dental Center you are with: ____ Phone Number? (_____)__________________

Address:____City:_______________________State:__________Zip:______________

Do you have any Dental Board problems that we should know about? [ ] Yes [ ] No (if yes; please use additional paper to explain)

NOTE: A yes answer to the above question DOES NOT automatically disqualify you from particiaption in our plan.

Skill comfort rating: On a scale of 0 - 10

0- means that you DO NOT perform the procedure 10 - means that you DO perform the procedure including very difficult cases

With this in mind, please rate your comfort and skill level in the following fields:- (please circle one number for each field)

Orthodontics	0	1	2	3	4	5	6	7	8	9	10	Pedodontics	0	1	2	3	4	5	6	7	8	9	10
Endodontics	0	1	2	3	4	5	6	7	8	9	10	Prosthodontics	0	1	2	3	4	5	6	7	8	9	10
Oral Surgery	0	1	2	3	4	5	6	7	8	9	10	T.M.J.	0	1	2	3	4	5	6	7	8	9	10
Periodontics	0	1	2	3	4	5	6	7	8	9	10	Implants	0	1	2	3	4	5	6	7	8	9	10

Optional information:

What is your Personal Mailing Address?____

City:____ State:________ Zip Code:__________Personal Phone Number? (_____)___________________

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