



**DENTAL CENTER &
SPECIALIST
ADD ON PACKET ALL ZONES**

(602) 841-3494 - 1-800-809-3494 - Fax (602) 589-0417

Corporate Office: Phoenix, Arizona

Mailing Address: PO Box 54277, Phoenix, AZ 85078

Website: www.SavonDentalPlan.com

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Provider Participation Made Simple!



Let's Get Started...

Credentialing Check List

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

FOR EACH DENTAL CENTER

[] The COMPLETED two (2) page CENTER PROFILE

PLEASE NOTE: If you have more than one (1) dental center, the two (2) page Center Profile is required for each center. Copies of these page are permissible

FOR EACH PROVIDER

[] The COMPLETED one (1) page PROVIDER PROFILE

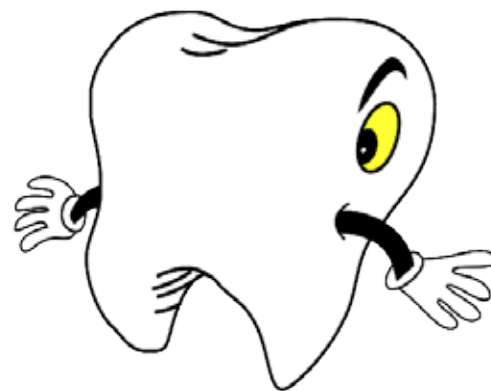
[] PROFESSIONAL LIABILITY INSURANCE POLICY NUMBER AND EXPIRATION DATE

[] 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

Center Profile



Please Tell Us About Your Office

What is the name of your practice? _____

What is the physical address of the Office? _____

City: _____ State: _____ Zip Code: _____

What is the office phone number?(_____)_____-_____ Fax Number?(_____)_____-_____

What is the name of your office manager or appointment coordinator? _____

Office Manager's email address: _____

Do you have a Web Site? Yes No If yes please give us your web address: www._____

If you have a web site would you like a link from our dentist list to your web site? Yes No

Is your office in a Metropolitan Area (over 100,000 people) Yes No (If no) miles from a Metro Area? _____ miles

Are languages other than English spoken in your office? Yes No (if yes, please specify) _____

Is the mailing address the same as the physical address? Yes No (If no, please give us the mailing address below).

Address: _____ City: _____ State: _____ Zip: _____

Please Tell Us About Your Operatories and Patient Capacity

How many operatories do you have? _____ How many assistants do you have? _____

Do you have a hygiene department? Yes No (if yes) How many hygienists do you have? _____

How many additional patients is your office willing to accommodate on a monthly basis? 10-20 21-50 51-70 71-90 91-100 over 100
(please circle the one that applies)

Please Tell Us About Options and Special Equipment that you have

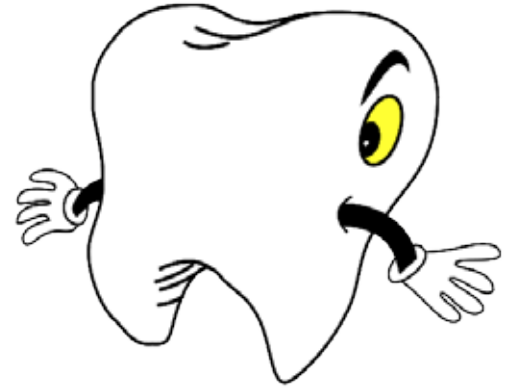
(please check all that apply to your office)

- | | | | | |
|---|--|--------------------------------------|--|---|
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Ultra Sonic Cleaning | <input type="checkbox"/> Laser | <input type="checkbox"/> Electro Surge | <input type="checkbox"/> IV Sedation |
| <input type="checkbox"/> Oral Sedation | <input type="checkbox"/> Prophyl Jet | <input type="checkbox"/> Denta Cam | <input type="checkbox"/> K.C.P. 2000 | <input type="checkbox"/> Brite Smile/Zoom (etc) |
| <input type="checkbox"/> High Speed Endo (ie Root ZX) | <input type="checkbox"/> Digital X-Ray | <input type="checkbox"/> Cavitron | <input type="checkbox"/> Children Sedation | <input type="checkbox"/> On site denture Lab |
| <input type="checkbox"/> On site Crown & Bridge Lab | <input type="checkbox"/> Panoramic x-ray machine | <input type="checkbox"/> Diode Laser | <input type="checkbox"/> CAD/CAM (cerec) | <input type="checkbox"/> 3D Imaging |

Other (please explain): _____

Center Profile

Page II



Please Tell Us What Days and Hours You are Open

Days Open: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Office Hours: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Please Tell Us About Your Payment Policy

Please check the credit cards that you accept: Mastercard Visa American Express Discover

Do you accept any other credit cards? Yes No (if yes, please specify) _____

Please check any of the following other forms of payments that you make available to patients

Personal Checks DentaCharge United Surgical Care Credit "In house" financing

Payment plans available through a finance company

Other (please explain): _____

Equipment Sterilization and Infection Control

Do you sterilize your instruments in office? Yes No (if yes) Type: Autoclave Chemclave Statem Steam Cold Other

Do you sterilize your handpieces in office? Yes No (if yes) Type: Autoclave Chemclave Statem Steam Cold Other

Do you spore test your sterilization unit? Yes No (If yes) how often? Daily Weekly Monthly Other

If other or no is checked for any of these questions please explain: _____

Personal Sterilization and Infection Control that is Used in this Office

In the Operatory, Do you wear: Mask Yes No Gloves Yes No

Eye Protection Yes No As Needed Protective Clothing Yes No As Needed

Emergency Control Procedures

Is your office equipped with Oxygen Yes No Is your office equipped with a Blood Pressure Device Yes No

Is your office equipped with a Defibrillator Yes No Does your office have at Least 1 C.P.R. Certified Person Yes No

Compliance Procedures

Does your office Meet O.S.H.A. Standards Yes No Does your office Have a Written Infection Control Policy Yes No

Does your office Have a Written Hazard Control Policy Yes No Does your office have a written H.I.P.P.A. policy Yes No

Is your office able to accommodate patients with Disabilities (Special question for our disabled members) Yes No

Office Philosophy

Please briefly describe your personal practice philosophy or practice emphasis: _____



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 ____/____/____

*Personal Emergency 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? ____/____/____

Who is your Professional Liability Insurance Carrier? _____

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

What is your D.E.A. Number? _____ When does it expire? ____/____/____

From what School did you receive your specialty training? _____

Are you Board Certified? Yes No (if yes; what year were you certified) _____

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 participation in our plan.

What is your area of specialty?

Orthodontics

Endodontics

Prosthodontics

Periodontics

Pedodontics

Oral Surgery

I also Treat TMJ

I also do Implants

For Orthodontists Only.

PREFERRED ORTHODONTIST (honors fee schedule)

PARTICIPATING SPECIALIST (25% discount)

All information in this profile is confidential and remains the property of Savon Professional Services, Inc., and Savon Dental Plan.®
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