|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PRACTICE INFORMATION** | | | | |
| Practice Type (Check One): ☐ Solo ☐Partnership ☐Professional Corporation ☐Other | | | | |
| Practice wishes to participate in: ☐ Commercial ☐ Medicaid ☐Medicare Advantage ☐Florida Healthy Kids | | | | |
| Provider’s Name: | | | | |
| Corporation’s Name (if applicable): | | | | |
| TIN: | | Group NPI (NPI-2,if applicable): | | |
| Practice Name: | | | | |
| Mailing Address: ☐Check here if multiple billing addresses | | | | |
| Billing Address: | | | | |
| Please indicate address to send signed Provider Agreement and Welcome packet: | | | | |
| Billing Address (if different from above): | | | | |
| Business Contact: | E-mail Address: | | Phone: | Fax: |
| Credentialing Contact: | E-mail Address: | | Phone: | Fax: |
| **OFFICE LOCATIONS** Please provide information for only those locations who will participate with Argus. | | | | |
| **Primary Office Location ☐Check here for additional office locations, attach separate page if needed** | | | | |
| Practice Name: | | | | |
| Complete Address (Street, City, State, Zip code): | | | | |
| Office Manager: | E-mail Address: | | Phone: | Fax: |
| Practice Name: | | | | |
| Complete Address (Street, City, State, Zip code): | | | | |
| Office Manager: E-mail Address: Phone: Fax: | | | | |
|  | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HOURS OF OPERATION** | | | | | | | | | | | | | | | | |
| **Monday** | **Tuesday** | | **Wednesday** | | | **Thursday** | | | | **Friday** | | | **Saturday** | | | **Sunday** |
| **Name of Provider(s) at this Location, INCLUDING THE APPLICANT. Please provide Medicaid numbers for each provider, as applicable**  **1. 2.**  **3. 4.** | | | | | | | | | | | | | | | | |
| **Please complete if different from above Practice Information** | | | | | | | | | | | | | | | | |
| Billing Address for this Location: | | | | | | | | | | | | | | | | |
| TIN for this Location (if different, please submit additional W-9): | | | | | | | | | | | | | | | | |
| **PATIENT RELATION SERVICES** | | | | | | | | | | | | | | | | |
| Languages Spoken by Provider: | | ☐English | | | | | ☐Spanish | | | | ☐French | | | | ☐Other: | |
| Language Spoken by Staff: | | ☐English | | | | | ☐Spanish | | | | ☐French | | | | ☐Other: | |
| Accepts Patients with Disabilities ☐Yes ☐No | | | | | | | | TTY Available ☐Yes ☐No | | | | | | Signing Available ☐Yes ☐No | | |
| Handicap Accessible Office (ADA Compliant) ☐Yes ☐No | | | | | | | | Handicap Parking Available ☐Yes ☐No | | | | | | | | |
| Accepting New Patients ☐Yes ☐No | | | | | Age of Patients from to\_ | | | | | | | Average Time for Appointment: Urgent ☐same day ☐1-2 days  ☐3+ days  New Patient ☐same day ☐1-2 days  ☐3+ days | | | | |
| Do you provide 24-hour coverage ☐Yes ☐No **24-hour emergency number**: | | | | | | | | | | | | | | | | |
| **PATIENT PROCEDURE SERVICES Please check all that are applicable** | | | | | | | | | | | | | | | | |
| Nitrous Oxide ☐Yes ☐No ☐N/A  General Anesthesia: ☐Yes ☐No | | | | IV Sedation: ☐Yes ☐No | | | | | |  | ☐Check here if not applicable Panoramic X-Ray: ☐Yes ☐No Intraoral X-Ray: ☐Yes ☐No | | | | | |
| Oral Sedation: ☐Yes | | | | | ☐No |  |
| Electronic Claims Submission: ☐Yes ☐No | | | | | | | | | ☐Check here if not applicable  Digital Radiograph Submission: ☐Yes ☐No | | | | | | | |
| Web Access: ☐Yes ☐No | | Sterilization Method:  ☐Autoclave ☐Chemiclave ☐Other: | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **To be completed by Provider. Please complete and attach all documents. Missing information will delay processing.** | | | | | | |
| **PROVIDER INFORMATION** | | | | | | |
| Provider’s Name (include suffix; Jr., Sr., III): | | | | | | |
| Maiden/Other Name(s) (if applicable): | | | | Owner | Associate | Employee |
| SSN: | | TIN (if different): | | ☐Male ☐ Female | | DOB: Click here to enter a date. |
| Individual NPI (NPI – 1): | | | | E-mail: | | |
| Individual Medicaid Number: Yes No In Process | | | | Individual Medicaid Number (if applicable): | | |
| Individual Medicare Number: Yes No In Process | | | | Individual Medicare Number (if applicable): | | |
| Are you enrolled in Medicare Part D ☐ Yes ☐ No ☐ In Process | | | | | | |
| Do you submit claims under your TIN or the Practice TIN Practice NA | | | | | | |
| **PROVIDER TYPE & PROFESSIONAL TRAINING** (Complete as applicable) | | | | | | |
| Provider Type: ☐Dental ☐ Routine Vision ☐Medical and Surgical ☐ Medical Only ☐Surgical Only   * Optical Facility | | | | | | |
| Vision Provider Type: | ☐Ophthalmologist | | Specialty: ☐Pedo ☐ Neuro ☐ Retina ☐ Oculoplastic ☐ Cornea | | | |
| ☐Optometrist  ☐Licensed Optician | |  | | | |
| Dental Provider Type: | ☐General Dentist | | Specialty: ☐Endo ☐Perio ☐Prostho ☐Pedo ☐ Ortho  ☐Oral Surgery | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Professional School: | | Degree: | Year Graduated: |
| Residency Program (if applicable): | | From: | To: |
| Fellowship or Advanced Training (if applicable): | | From: | To: |
| Board Certified? Yes (select certifying board below) No | | | |
| Dentistry  American Board of General Dentistry American Board of Endodontics American Board of Oral Surgery American Board of Orthodontics American Board of Pediatrics American Board of Periodontology American Board of Prosthodontics Other: | Vision  American Board of Optometry American Board of Ophthalmology American Osteopathic Association  American Association of Physician Specialists Other: | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| LICENSING INFORMATION Please attach copies of current documents identified below. | | | | |
| State Licenses:  Please attach copies of current license(s) and certificate(s) | State: | License Number: | Eff. Date: | Exp. Date: |
| State: | License Number: | Eff. Date: | Exp. Date: |
| State: | License Number: | Eff. Date: | Exp. Date: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DEA Certificate | Number: | Eff. Date: | Exp. Date | * Not Applicable |
| Controlled Substance Certificate (CDS) | Number: | Eff. Date: | Exp. Date | * Not Applicable |
| General Anesthesia Permit | Number: | Eff. Date: | Exp. Date: | * Not Applicable |
| ACLS Certificate | Number: | Eff. Date: | Exp. Date: | * Not Applicable |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PRIVILEGES:** ☐ASC ☐Hospital | | | | **If Medical Provider only and not applicable, check here** | | | | | |
| Facility Name: | | | | Address: | | | | | |
| City: | | | | State: | | | Zip: | | |
| Phone Number: | | | | Contact Name: | | | | | |
| Date Privileges Granted: | | | | Type of Privileges: | | | | | |
| **For additional hospitals, please copy, and submit with this application.** | | | | | | | | | |
|  | | | | | | | | | |
| **PROFESSIONAL LIABILITY INSURANCE INFORMATION** | | |  | **Please attach a copy of your current Insurance Declaration page or Certificate of Insurance.** | | | | | |
| Professional Liability Insurance Carrier: | | | | | | | | Policy #: | |
| Limits of Coverage: | Individual: | | | | | Aggregate: | | | |
| Eff. Date (MM/DD/YYYY): | | | | | Exp. Date (MM/DD/YYYY): | | | | |
|  | | | | | | | | | |
| **WORK HISTORY** | **In lieu of completing the section below, you may attach a resume or Curriculum Vitae. To be acceptable, Resume or Curriculum Vitae must show last 5 years of employment, including CURRENT EMPLOYMENT, and both MONTHS and YEARS of employment.** | | | | | | | | |
| Please include **CURRENT EMPLOYMENT**. Explain any gaps of six (6) months or more on a separate piece of paper. Must list last 5 years of employment. | | | | | | | | | |
| Dates To/From (MM/YY – MM/YY) | | Employer | Address | | | | | | Phone |
|  | |  |  | | | | | |  |
|  | |  |  | | | | | |  |
|  | |  |  | | | | | |  |
|  | |  |  | | | | | |  |
|  | |  |  | | | | | |  |



|  |  |  |  |
| --- | --- | --- | --- |
| **PROFESSIONAL REFERENCES** | | | |
| List at least **two** *(*2) professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. | | | |
| Name of Reference: | Title and Specialty: | E-mail Address: | |
| Mailing Address: | | | |
| Telephone Number: | Fax Number: | Cell Phone Number (Optional): | |
| Name of Reference: | Title and Specialty: | E-mail Address: | |
| Mailing Address: |  |  | Mailing Address: |
| Telephone Number: | Fax Number: | Cell Phone Number (Optional): | |



**PROFESSIONAL HISTORICAL DATA QUESTIONNAIRE**

# The following must be answered by Provider.

Any “Yes” response will require a detailed explanation and must be submitted along with the Dental Provider Application.

|  |  |  |
| --- | --- | --- |
| 1. | Have you ever been convicted of a felony or do you have any pending misdemeanor and/or felony charges? | Yes No |
| 2. | Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned, or otherwise limited? | Yes No |
| 3. | Have you ever been publicly reprimanded or disciplined by a professional licensing agency or Board? | Yes No |
| 4. | Has your DEA certification and/or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited? | Yes No |
| 5. | Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited? | Yes No |
| 6. | Has your participation in Medicare, Medicaid or any other government program ever been limited, expelled, excluded or have you voluntarily excluded yourself from any of these programs? | Yes No |
| 7. | Have you ever been convicted or pled “nolo contendere” to a criminal offense related to Medicare, Medicaid or any other Federal program? | Yes No |
| 8. | Has your participation in an HMO and/or an Insurance Company network ever been limited, restricted, suspended or terminated? | Yes No |
| 9. | In the past five years, up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? | Yes No |
| 10  . | Considering the essential function of a practitioner in your area of practice, in the past five years, up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients? | Yes No |



|  |  |  |
| --- | --- | --- |
| 11  . | In the past five years and up to and including the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? | Yes No |
| 12  . | Are you currently participating or under supervision of a Physician or Recovery Network or applicable program? | Yes No |
| 13  . | Has any malpractice carrier made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf in the past 5 years or are any medical malpractice suits pending against you? | Yes No |
| 14  . | Are you currently uninsured for professional liability (malpractice insurance) coverage? | Yes No |
| 15  . | Has your malpractice/professional liability insurer placed conditions or restrictions on your coverage or ability to obtain coverage in the past 10 years? | Yes No |

[Intentionally Left Blank. Provider Attestation, Authorization, and Release of Information Form on Next Page.]



|  |
| --- |
| **PROVIDER ATTESTATION, AUTHORIZATION, AND RELEASE OF INFORMATION FORM** |
| By submitting this authorization and release of information form, I understand and agree as follows:  I understand and acknowledge that, as an applicant for participating status with Argus Dental & Vision, Inc. for initial credentialing or re-credentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and/or other qualifications.  I further understand and acknowledge that Argus Dental & Vision, Inc. or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of Argus Dental & Vision, Inc. as part of the verification and credentialing process.  I authorize Argus Dental & Vision, Inc., and its subsidiaries, affiliates, successors, employees, agents, authorized representatives, and third parties (hereinafter “ADV”), to consult with hospitals, members of hospital medical staffs, professional liability carriers, managed care organizations and other persons or entities to obtain information concerning my professional credentials and qualifications, including without limitation my professional competence and conduct. Such authorization to obtain information includes but is not limited to information about my quality of care and utilization statistics from chiefs of the clinical departments of a hospital in which I have staff privileges, professional state boards, applicable state and federal agencies, and primary care and specialist physician colleagues participating with ADV.  I authorize all individuals, institutions and entities of organization with which I am currently or have been associated with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to ADV.  I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.  I consent to the release to ADV of any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged.  I authorize ADV to release this information, as well as quality assurance data relating to me: (1) to health/dental/vision plans/programs owned, managed, or administered by ADV, (2) to health/medical/dental/vision groups, independent practice associations and similar entities contracting with said health/medical/dental/vision plans/programs has delegated credentialing functions to such entities, and (3) as authorized under state or federal law or regulation.  I release ADV and any and all persons or entities providing information about me to ADV, from any and all liability connected with or arising from the release of such information, provided that such party(ies) was(were) acting in good faith without malice. I further release ADV from any and all liability for its acts performed in good faith and without malice in evaluating my application and any decisions related to my application or credentialing status. |



|  |  |
| --- | --- |
| I understand and agree that any misstatement or material omission in this application will constitute grounds for rejection of my application or summary dismissal as a participating provider in any and all managed care products or plans maintained or managed by ADV. If any material changes occur in the information I have provided in this application making such information no longer correct and complete or affecting my professional status, I understand and agree that it is my obligation to notify ADV within ten (10) days of said occurrence. Failure to comply with this obligation may constitute grounds for rejection of my application or summary dismissal as a participating provider in any and all managed care products or plans maintained or managed by ADV.  I understand that completion and submission of this application and Attestation and Release of Information Form (“Release”) does not automatically grant me membership or participating status with Argus Dental & Vision, Inc.  I further acknowledge that I have read and understand this Release. A photocopy of this Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.  I attest that the information in this application is complete, accurate, and current. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below. | |
| Provider Signature (NO SIGNATURE STAMP) | Date |
| Printed Name: | |



|  |  |  |  |
| --- | --- | --- | --- |
| **Additional Office Locations** Please provide information for only those locations who will participate with Argus. | | | |
|  | | | |
| Practice Name: | | | |
| Complete Address (Street, City, State, Zip code): | | | |
| Office Manager: | E-mail Address: | Phone: | Fax: |

|  |
| --- |
| Practice Name: |
| Complete Address (Street, City, State, Zip code): |
| Office Manager: E-mail Address: Phone: Fax: |
| Practice Name: |
| Complete Address (Street, City, State, Zip code): |
| Office Manager: E-mail Address: Phone: Fax: |
| Practice Name: |
| Complete Address (Street, City, State, Zip code): |
| Office Manager: E-mail Address: Phone: Fax: |
| Practice Name: |
| Complete Address (Street, City, State, Zip code): |
| Office Manager: E-mail Address: Phone: Fax: |