July 29, 2025 A Credentials Verification Organization

MetLife/SafeGuard Health Plans Inc.

Important Notice of Name Change

THIS FORM IS FOR:
KRUNAL PATEL, DDS/DMD
Menifee Lakes Dental Group
29121 NEWPORT RD STE 101
MENIFEE, CA 92584

Phone To: (888) 273-3368
Fax To: (949) 470-0838
Mail To: VPoint™
1 Spectrum Pointe Dr., Suite 320,
Lake Forest, CA 92630
Online: www.valenzhealth.com/vpoint
Email: providers@valenzhealth.com

Please check if applicable and return immediately:
☐ Provider is Retired ☐ Provider is Deceased
☐ Provider left practice. New contact information (if known):
Address:_____
Email:_____Phone:_____Fax:_____

Dear KRUNAL PATEL,

License #: 107748 **VPoint™ Provider ID:** 1027822414
VPoint™ Practice ID: 1599685

As your Credentialing Verification Organization, we are thrilled to announce we have changed our name to VPoint™ and joined the Valenz® family. VPoint™ is now part of the Valenz Healthcare Ecosystem Optimization Platform, a fully integrated suite of solutions for providers and payers. For more information visit www.valenzhealth.com/vpoint

Valenz® VPoint™, has been contracted to perform credentialing for the organization listed above. Regardless of whether you have recently been credentialed through another health plan or organization, you are required to be credentialed at this time.

Please review the pre-populated credentialing application and make any necessary updates or corrections. All sections must be completed, including the Questionnaire/Attestation if provided. Incomplete applications will result in a delay in your credentialing process and generate multiple requests for information.

A completed credentialing application and required documents must be returned to VPoint™ within 14 days of receipt of this letter. **Failure to return these documents timely may affect your participation with the organization(s) listed above.** Please remit the required documents to VPoint™ via email, fax or mail listed above.

If you have any questions regarding this request, please contact us at (888) 273-3368 and reference your VPoint™ Provider ID number listed above.

Thank you for your cooperation,

Provider Relations
VPoint™
www.valenzhealth.com/vpoint

Comments:

Dear Practitioner, KRUNAL KAUSHIKBHAI ,PAT

VerifPoint/Credentialing Solutions (VPCS) has been contracted to perform recredentialing for SafeGuard Health Plans, Inc. ("SafeGuard" or the “Plan”). Regardless of whether you have recently been credentialed or submitted your complete recredentialing application in the previous year, you are required to be recredentialing at this time.

Please review the recredentialing application and make any necessary updates or corrections. A**ll section must be completed, including the Questionnaire/Attestation**. Incomplete application will result in a delay in you recredentialing process and generate multiple requests for information.

A completed recredentialing application and required documents (**current PLI, License, DEA and in the case of a specialist, a copy of the Specialty School Graduation Certificate**) must be returned within 14 days of receipt of this letter. Failure to return these documents timely may affect your participation SafeGuard Health Plans, Inc. ("SafeGuard" or the “Plan”).

If you have any questions regarding this request, please contact us at (888) 273-3368 and reference your VerifPoint ID number listed above.

Thank you for your cooperation,
Provider Relations
VerifPoint/Credentialing Solutions
www.verifpoint.com

Metropolitan Life Insurance Company
MetLife Health Plans, Inc.
SafeGuard Health Plans, Inc.

DENTAL PROVIDER RECREDENTIALING APPLICATION

SECTION 1: Provider Information

The participating provider must complete the entire application. If any section is not applicable, please write "N/A".

Specialty: ☐ General Dentist ☐ Endodontist ☐ Oral Surgery ☐ Orthodontist ☐ Pedodontist ☐ Periodontist

Dentist Name
KRUNAL KAUSHIKBHAI ,PATEL ☐ DDS ☐ DMD ☐ Owner ☐ Associate

Gender: ☐ Male ☐ Female	DOB	SSN #	Tax ID #

Dental School	Graduation Year

Specialty School	Graduation Year

Specialty Board Certified? ☐ Yes ☐ No	Issuing Board

Hospital privileges? ☐ Yes ☐ No	Hospital Name(s)

Hospital(s) Address	Hospital(s) Telephone

State License #	Expiration Date	In good standing? ☐ Yes ☐ No

DEA Certificate #	Issue Date	Expiration Date

State Controlled Substance #	Issue Date	Expiration Date

General Anesthesia #	Issue Date	Expiration Date

CPR Certificate #	Issue Date	Expiration Date

Medicaid Permit #	Group NPI #	Provider NPI #

Name of Professional Liability Carrier	Policy #

Expiration Date	Amounts of Coverage: Individual	Aggregate

NOTE: A current copy of your professional liability insurance certificate, dental license, and DEA/Controlled substance permit may be included with this information.

Name of Primary Facility: _____

Hours Worked At This Facility:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open:							
Lunch:							
Close:							

Do you practice in another SafeGuard contracted facility? ☐ Yes ☐ No	If Yes, Facility #

SECTION 2: Attestation Form

Please answer all of the following questions. Explain any "Yes" answers on a separate sheet of paper, including dates, underlying circumstances and disposition.

		Yes	No
1.	Has your DEA certificate and/or state controlled substance authorization ever been denied, revoked, or restricted in any way?	☐	☐
2.	Have you had any malpractice or other professional liability judgements or settlements in the last ten (10) years?	☐	☐
3.	Do you have any malpractice or other professional claims currently pending against you (whether a formal notice of claim or a lawsuit)?	☐	☐
4.	Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you been denied professional liability insurance or coverage for any procedures?	☐	☐
5.	Has your dental license ever been denied, revoked, suspended, or placed on probation or otherwise been subject to any other disciplinary action in any state?	☐	☐
6.	Have you ever been convicted of a felony?	☐	☐
7.	Has your board certification or any hospital privilege ever been suspended, revoked, or restricted?	☐	☐
8.	Have you ever been sanctioned by or the subject of any potential censure or disciplinary action by a local dental society or peer review body?	☐	☐
9.	Do you have any physical or mental illness, disease, or impairment that would interfere with your ability to practice or that would endanger patients?	☐	☐
10.	Do you presently use any illegal substances?	☐	☐
11.	Have you ever had or been advised to seek treatment for any chemical dependency or substance abuse condition?	☐	☐
12.	Have you ever been sanctioned or denied participation in any federal or state health benefits program (e.g. Medicare or Medicaid)?	☐	☐
13.	Have you ever been terminated for cause, refused membership or has your membership been revoked, suspended or limited on a health care facility professional staff, in a managed care plan or network, or in a PPO network?	☐	☐

SECTION 3: Acknowledgement & Signature

All information provided in this document is complete and accurate to the best of my knowledge. I understand that my application for participation in the SafeGuard program may require SafeGuard or its designee to review information listed above. I hereby authorize the release of such information to SafeGuard and its authorized designee. I further understand that all information provided in this document will be held in confidence by SafeGuard, to the extent permitted by law. I agree that SafeGuard and its agents acting in good faith shall not be liable for any action or omission related to the evaluation or verification of information provided in this document. I further agree to notify SafeGuard in a timely manner (not to exceed thirty (30) days) of any change to the information requested by this document. I understand that submission of this application does not constitute approval or acceptance of the Dentist as a SafeGuard contracted dentist. I understand that I must meet SafeGuard's criteria for participation.

By signing this application, I hereby acknowledge that I have read, understood each of the questions contained in this document and that I certify that to the best of my good faith knowledge and belief, the responses I provided here are accurate, complete and true.

Dentist's Name (Print): **KRUNAL KAUSHIKBHAI ,PATEL** Dental License: _____

Signature: _____ Date: _____

SECTION 4: Dental Career History (for the past 5 years)

Employment dates must be stated by month and year. Any gaps over six months will require clarification in writing; use a separate sheet of paper if necessary.

Practitioner Full Name (Please Print): KRUNAL KAUSHIKBHAI ,PATEL

☐ Check here if you have practiced in this same location for the past 5 years.

1.
Practice Name | Phone
Address
City | State | Zip
Start Date (MONTH/YEAR) | End Date (MONTH/YEAR)

2.
Practice Name | Phone
Address
City | State | Zip
Start Date (MONTH/YEAR) | End Date (MONTH/YEAR)

3.
Practice Name | Phone
Address
City | State | Zip
Start Date (MONTH/YEAR) | End Date (MONTH/YEAR)

4.
Practice Name | Phone
Address
City | State | Zip
Start Date (MONTH/YEAR) | End Date (MONTH/YEAR)

5.
Practice Name | Phone
Address
City | State | Zip
Start Date (MONTH/YEAR) | End Date (MONTH/YEAR)

SafeGuard

SAFEGUARD DENTAL & VISION
PRACTITIONER RIGHTS

I. Practitioner's Right to Review and/or Request Credentialing Application Status

Practitioners have the right to review information SafeGuard acquires in order to evaluate the credentialing or re-credentialing of their application. This includes non-privileged information from any non-SafeGuard source such as insurance carriers, state licensing boards or the National Practitioner Data Bank. Practitioners may not review any information that may not legally be disclosed. Upon written request, SafeGuard's Credentialing Department will provide details of the status of their initial credentialing or re-credentialing process.

A review may be requested by writing or sending a fax to Manager of Credentialing, SafeGuard, 5 Park Plaza, Suite 1850, Irvine, California 92614. The **fax number is: (949) 360-3693**. The practitioner will be notified within 72 hours of receipt of the request by the credentialing manager of the date and time when the information will be ready for review at SafeGuard's Credentialing Department.

II. Practitioner's Right to receive Notice of Discrepancy

Practitioners will be notified by letter or fax when information obtained from primary sources varies substantially from that provided by the practitioner on the application. Such information includes, but is not limited to, malpractice history, license revocation, suspension and expiration of board certifications. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if the information is not intended for credentialing verification or if it cannot legally be disclosed.

III. Practitioner's Right to Initiate Correction of Erroneous Information

If a practitioner finds information supplied by primary sources that is in error, it may be corrected by submitting written notification to SafeGuard's Credentialing Department. Practitioners must submit notice by letter or fax along with a detailed explanation to the Manager of Credentialing, SafeGuard, 5 Park Plaza, Suite 1850, Irvine, CA 92614. The **fax number is: (949) 360-3693**. Notification to SafeGuard must be made within 48 hours of SafeGuard's notification to the practitioner of a discrepancy as provided in Section II above or within 24 hours of a practitioner's review of his/her credentials file as provided in Section I above.

Upon receipt of notification, SafeGuard will re-verify the disputed primary source information. If the primary source information has changed, a correction will be made immediately to the practitioner's credentials file and the practitioner will be notified by letter or fax of the corrective action. If primary source information remains inconsistent with the practitioner's notification, the Credentialing Department will notify the practitioner via letter or fax. The practitioner may then provide proof of correction by the primary source body to SafeGuard's Credentialing Department via letter or fax within 10 work days. The Credentialing Department will re-verify primary source information if such documentation is provided and take action as necessary. If after 10 working days the primary source information remains in dispute, the practitioner will be subject to action under SafeGuard's Appeal, Denials, and Termination Process, up to and including administrative denial or termination.