# Dentist Application

HUMANA
*Specialty Benefits*

Separate dentist applications are required for each associate. To expedite processing of your application, please print clearly or type. Answer all questions or indicate "Not Applicable." If there are additional physical locations or if the billing address differs from the physical address, please submit on a separate page.

## Your Profile

First, Middle, Last name — Circle one: DDS / DMD

Primary service address — Specialty

City — State — Zip

Phone — Fax — Email

Tax identification (ID) number — Provider NPI number

Name registered with tax ID number — ❑ Individual ❑ Corporation

## Education and Professional Licensure

Dental license number — Expiration date — State

Federal DEA registration number — Expiration date

Dental school — Year graduated

Specialty residency institution (attach certificate) — Year graduated

## Professional Liability

**If you answer yes to any of the following questions, attach a written explanation to your application.**

1. Has your license to practice dentistry ever been denied, limited, suspended, revoked, or voluntarily or involuntarily relinquished? ❑ No ❑ Yes
2. Have you had a lapse in your practice history over the past five years? ❑ No ❑ Yes
3. Have any professional liability suits, actions, or claims alleging malpractice been filed against you, or have you entered into any settlements? ❑ No ❑ Yes
4. Has your Federal DEA and/or state controlled dangerous substance certifications, been limited, suspended, revoked or voluntarily or involuntarily relinquished? ❑ No ❑ Yes
5. Have you been suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health insurance program (Medicare, Medicaid, etc.)? ❑ No ❑ Yes
6. Have you ever had, or have you ever been advised to seek treatment for a chemical dependency or substance abuse condition? ❑ No ❑ Yes
7. Do any reasons exist which would cause the inability to perform essential functions of the position with or without accommodation? ❑ No ❑ Yes
8. Have you been convicted of a felony or misdemeanor other than minor traffic violations? ❑ No ❑ Ye

## Attestation Statement / Consent and Release Form

I understand the information given, in or attached to this application will be used to determine my eligibility for participation in HumanaDental's dental networks.

I acknowledge and agree I comply with the terms and conditions of the Service Agreement.

I attest that my professional liability insurance is currently active, and is greater than or equal to $100,000 individual coverage and $300,000 aggregate coverage. In Florida, $250,000 individual coverage and $750,000 aggregate coverage.

I certify that information given, in or attached to this application is accurate and complete to the best of my knowledge. As a condition of this application, any misrepresentation or misstatement in, or omission from it, whether intentional or not, shall constitute grounds for rejection of my request for continued participation with HumanaDental.

I agree to notify HumanaDental of any changes, as they occur, to information given, in or attached to this application.

I agree to hold harmless and from any and all liability, HumanaDental, its authorized representatives and any third parties, for any acts performed in good faith and without malice relating to any communication or disclosures of any kind, involving me which are performed, otherwise privileged or confidential information. Any and all information obtained by HumanaDental shall be confidential to the fullest extent permitted by law.

Dentist agrees to accept as payment in full, HumanaDental's fee schedule or dentist's usual and customary charges, whichever is less, less any copayments due from member.

Dentist agrees to accept as payment in full the HumanaDental fee schedule paid by members of a HumanaDental access program. These programs will be identified on the member's identification card and require no claim submission or preauthorization. Member is responsible for the entire amount per procedure as identified in the fee schedule.

I hereby acknowledge that this Consent and Release Form is valid for the lifetime of the contract, and that a photocopy or fax will serve as an original.

**Applicant's Signature** _____ **Date** _____

**Return address:** HumanaDental Network Development
N19 W24133 Riverwood Drive, Suite 300
Waukesha, WI 53188
**Fax:** 920-632-0121

**HumanaDental use only**

❑ PPO CIS #_____
❑ DHMO Deal #_____ Network _____
❑ Access DNR _____

**Please photocopy for your records**