Capitol Dental Care

☐ **INITIAL CREDENTIALING** ☐ **RE-CREDENTIALING**

INSTRUCTIONS
Please complete the following information and make corrections as appropriate. Please do not leave any blanks. Be sure to sign both, the attestation at the bottom of this page and the Provider Release and Authorization form.

PROVIDER INFORMATION

_____
Last Name First Middle

_____
Office Phone Office Fax E-mail

Dental License No: _____ State: _____ Expiration Date: _____

Date of Birth: _____ DEA Number: _____ Expiration Date: _____

Tax ID#: _____ National Practitioner Identifier (NPI): _____

Health Services Program Number (MAP): _____

CREDENTIALING APPLICATION

Have you completed an OPCA or OPRA within the last 30 days? Yes _____ No _____

Have you completed a PROVIDER INTAKE FORM? Yes _____ No _____

Are you credentialing/re-credentialing to practice at more than one location? Yes _____ No _____

Have you been employed by Capitol Dental Care or any of its affiliates in the past? Yes _____ No _____

If yes, please indicate affiliate and the dates of employment. _____

Anticipated Start Date *(for Initial Credentialing only)* _____

I attest that the information on the OPCA/OPRA application is correct and complete.

_____ _____ _____
Signature Degree Date

****Please attach current copies of the following when returning your OPCA/OPRA application:*

☐ *Provider Enrollment Agreement* ☐ *Provider Intake Form*

☐ *Oregon Dental license(s)* ☐ *DEA certificate*

☐ *Proof of Liability Insurance: reflecting provider name, policy effective/term date and per occurrence/aggregate amounts.*

Please send completed credentialing packet by email to comers@interdent.com or by fax to 1-877-646-8688.

PROVIDER RELEASE AND AUTHORIZATION

Capitol Dental Care

In association with my application to be a participating dentist with the entity indicated above, I hereby:

Agree to the release, by any individual or party, for the above indicated entity, to obtain information regarding my education, licensure or certifications, disciplinary actions, malpractice history, or other related confidential or privileged information for the purpose of verifying my qualifications to practice dentistry.

Agree to notify the above indicated entity at once of any important changes which may affect my practice of dentistry.

Release the above indicated entity and their employees from obtaining information and evaluating my application: I further release from any liability any other persons or entities providing information as authorized hereunder if acting in good faith and without malice.

State that this authorization/release is restricted to those matters specified and that the above indicated entity will treat all information obtained by them in a confidential manner and will not release such information to others without my prior consent.

Agree that a photocopy of the document will serve the same purpose as the original.

_____

Signature

_____

Print Name

_____

Date Signed

PROVIDER ENROLLMENT DISCLOSURE STATEMENT