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: _____

Individual TIN: _____ NPI: _____ DMAP: _____

Practice/Business Name _____

Organizational TIN: _____ NPI: _____ DMAP: _____

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 include the following when returning your credentialing packet:***

☐ *OPCA/OPRA* ☐ *Provider Enrollment Agreement (pages 1-3)* ☐ *Provider Intake Form*

☐ *CDC Attestation & Release* ☐ *Oregon DEA certificate (if applicable)*

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

☐ *Oregon Dental/Hygiene License* ☐*Collaborative Agreement (if applicable)*

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