DELTA DENTAL

Provider Association Form

Delta Dental of New Mexico

Instructions

This form is for active Delta Dental Participating Providers who have begun practicing in a new office location. Fill in all fields and submit your application to notify Delta Dental of New Mexico about the additional office location. Each Participating Provider in a group practice must complete a separate application for each additional office location.

Please enclose a copy of the following with this completed application:

1. All applicable signed Delta Dental Participating Provider Agreements
2. Current state(s) license(s) and specialty certification
3. Current professional liability (malpractice) certificate declaration page (each Participating Provider in a group practice must include the requested information)
4. Copy of sedation license, if applicable
5. DEA and CDS certificates, if applicable
6. CPR or Basic Life Support certificate
7. IRS Form W-9

Section 1 – Provider Information

Name (Last, First, Middle Initial)		Suffix (e.g., Jr., III)	Gender: ☐ M ☐ F
Social Security Number	Date of Birth (MM/DD/YYYY)		
NM State License Number	Specialty		
National Provider Identification (NPI) Number Type 1			

Section 2 – Additional Practice Location

Business Name		Tax Identification Number (TIN)
Street Address (including City, State, and ZIP Code)		
Telephone	Fax	Office Email Address
Is this a Primary Practice Location? ☐ Y ☐ N **Note:** A Primary Practice Location is defined as a location where you are scheduled to see Delta Dental patients at least one day per month. You can have multiple Primary Practice Locations.		
If not currently practicing here, what is your expected start date? Note: We cannot process applications submitted more than 30 days before the start date.		Expected Start Date (MM/DD/YYYY)

Section 3 – Standard Authorization, Attestation, and Release

I understand and agree that, as part of the credentialing application process for participation, membership, and/or clinical privileges (hereinafter referred to as "Participation") with Delta Dental, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by Delta Dental for determining initial and ongoing eligibility for Participation. Delta Dental and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that Delta Dental has criteria for acceptance, and I may be accepted or rejected. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that Delta Dental will grant me clinical privileges or contract with me as a Provider of services. I understand that my application for Participation with Delta Dental is not an application for employment with Delta Dental and that acceptance of my application by Delta Dental will not result in my employment by Delta Dental.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, Delta Dental, its representatives, employees, and/or designated agent(s); Delta Dental's affiliated entities and their representatives, employees, and/or designated agents; and Delta Dental's designated professional credentials verification personnel (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow Delta Dental and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to Delta Dental and/or its Agent(s) information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, Delta Dental. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation, and Release.

I certify that the information contained herein, including all supporting materials, is true and complete to the best of my knowledge and belief. I understand and agree that my application will be reviewed based upon the information I have provided and other information obtained by Delta Dental of New Mexico in accordance with its credentialing program. I further understand and agree that information which is found to be false, or any misstatement or material omission, will constitute grounds for rejection of my application and could result in the termination of my Delta Dental Participating Provider Agreement. I further agree to notify Delta Dental of New Mexico, in writing, of any change in the information I have provided in this document regarding my professional liability coverage or any action against my professional license within 30 days of its occurrence.

I authorize the New Mexico Board of Dental Health Care (or other dental licensing agencies in any state in which I have been licensed to practice dentistry), and any health care facility, health maintenance organization, or professional organization with whom I have had employment, practice, association, or privileges, to release information to Delta Dental regarding any pending or final disciplinary or malpractice action.

Release from Liability. I release from all liability and hold harmless Delta Dental, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of Delta Dental, its Agent(s), or other third party in connection with the gathering, release, and exchange of, and reliance upon, information used in accordance with this

Authorization, Attestation, and Release. I further agree not to sue Delta Dental, any Agent(s), or any other third party for their acts, defamation, or any other claims based on statements made in good faith and without malice or misconduct of Delta Dental, Agent(s), or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation, and Release, all references to Delta Dental, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and Agents. Delta Dental or any of its affiliates or Agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation, and Release is irrevocable for any period during which I am an applicant for Participation with Delta Dental, a member of Delta Dental's health care staff, or a Participating Provider of Delta Dental. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by Delta Dental in accordance with the applicable bylaws, rules and regulations, and requirements of Delta Dental, or grounds for my termination of Participation at or with Delta Dental. I agree that information obtained in accordance with the provisions of this Authorization, Attestation, and Release is not and will not be a violation of my privacy.

I understand that submission of this application is not a guarantee of its approval and that Delta Dental reserves the right to reject an application for any reason it deems appropriate or necessary.

______________________________ Provider Signature

______________________________ Provider Name (print)

______________________________ Date Signed

______________________________ Signature of the Person Submitting this Form

______________________________ Name of the Person Submitting this Form (print)

______________________________ Date Signed

Please email a copy of completed application to providerrelations@deltadentalnm.com, or mail your application to:

Delta Dental of New Mexico
2500 Louisiana Blvd. NE STE 600
Albuquerque, NM 87110

Telephone: (505) 883-4777
Toll-Free: (800) 999-0963
Fax: (505) 883-7444