RESET FORM

Ameritas Dental Network Application

Ameritas

Ameritas Life Insurance Corp., Ameritas Life Insurance Corp. of New York

1. The Office: Please provide the following information for your office listing. **Paperwork should be completed and signed by owner of practice.**

Owner Name _____ ☐ DDS ☐ DMD

Gender: ☐ M ☐ F Date of Birth_____ S.S. #_____

License #_____ Expiration Date _____ DEA Certificate #_____ Expiration Date _____

Specialty: ☐ GP ☐ Ortho ☐ Perio ☐ OS ☐ Endo ☐ Prost ☐ Pedo

If specialist, Board Status:
Eligible? ☐ Yes ☐ No
Certified? ☐ Yes ☐ No

If not board certified, highest level of education obtained: _____

A. Primary Location: Business Name _____

TIN used for claim payment _____ **IRS name**_____

Address/City/State/ZIP_____

Phone (_____) _____ Fax (_____) _____ Office e-mail_____

Office website _____ Advertise email and website? ☐ Yes ☐ No

*See the permitted uses for the email address/website set forth in the section captioned "authorization and release"

Accepting New Patients? ☐ Yes ☐ No Do you administer general anesthesia? ☐ Yes ☐ No If yes, Permit #_____

Please indicate your office hours for this location:

Mon._____ Tues._____ Wed._____ Thurs._____ Fri._____ Sat._____ Sun._____

Please list all languages other than English spoken: _____

B. Secondary Location: Business Name_____

TIN used for claim payment _____ **IRS name**_____

DEA Certificate #_____ Expiration Date_____ (if different than above)

Address/City/State/ZIP _____

Phone (_____) _____ Fax (_____) _____ Office e-mail _____

Office website _____ Advertise email and website? ☐ Yes ☐ No

*See the permitted uses for the email address/website set forth in the section captioned "authorization and release"

Accepting New Patients? ☐ Yes ☐ No Do you administer general anesthesia? ☐ Yes ☐ No If yes, Permit #_____

Please indicate your office hours for this location:

Mon._____ Tues._____ Wed._____ Thurs._____ Fri._____ Sat._____ Sun._____

Please list all languages other than English spoken: _____

2. Billing Address: Only claim checks to Billing Address: ☐ Yes ☐ No All correspondence/mailings to Billing Address: ☐ Yes ☐ No

Street Address_____ Suite _____

City _____ State_____ ZIP _____ Phone (_____) _____

List the name of each additional dentist who will be providing services in your office under the corporate TIN# and Agreement.
Attach separate sheet for any additional providers and/or locations.

	Name	DDS	DMD	State License Number	GP	Ortho	Perio	OS	Endo	Prost	Pedo
DR. 1		☐	☐		☐	☐	☐	☐	☐	☐	☐
DR. 2		☐	☐		☐	☐	☐	☐	☐	☐	☐

DR. 1 — **Gender:** ☐ M ☐ F **Location:** ☐ Primary ☐ Secondary

If specialist, Board Status:
Eligible? ☐ Yes ☐ No
Certified? ☐ Yes ☐ No

If not board certified, highest level of education obtained: _____

DR. 2 — **Gender:** ☐ M ☐ F **Location:** ☐ Primary ☐ Secondary

If specialist, Board Status:
Eligible? ☐ Yes ☐ No
Certified? ☐ Yes ☐ No

If not board certified, highest level of education obtained: _____

The following information is to be completed by the owner of the practice.

3. Education and Training: Completion of health care professional and/or post-graduate training, other than the highest level of education obtained.

College _____ Dates_____

Dental School _____ Dates_____

Residency _____ Dates_____

Address _____

4. Work History

List professional work history for the last five (5) years, beginning with the most recent, including academic appointments. Explain any gaps of six months or more on a separate sheet.

Practice/Employer _____

Mailing Address _____

Dates of Employment: From_____ To_____

Reason for Leaving _____

Practice/Employer _____

Mailing Address_____

Dates of Employment: From_____ To_____

Reason for Leaving _____

5. License History

Please provide history of licensure in all jurisdictions.

State _____ License Number _____ Dates Held_____

State _____ License Number _____ Dates Held_____

6. Licensing Information

1. Have any of the following items ever been denied, revoked, suspended, not renewed, placed on probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions; or are there actions pending with respect to any of the following items:
   - State license . . . . . ☐ Yes ☐ No
   - DEA, or other applicable narcotic registration . . . . . ☐ Yes ☐ No
   - Professional organization membership . . . . . ☐ Yes ☐ No
   - Hospital or other health-care facility staff membership or privileges . . . . . ☐ Yes ☐ No
   - Medicaid or other government program participation . . . . . ☐ Yes ☐ No
   - HMO, PPO or other managed care plan . . . . . ☐ Yes ☐ No
2. Are there any reasons you are not able to perform all the services required by your agreement, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? . . . . . ☐ Yes ☐ No
3. Have you ever been involved in any malpractice suit(s) or arbitration(s), or has any settlement ever been paid by you or on your behalf? . . . . . ☐ Yes ☐ No
   If **YES**, please explain for each suit, arbitration or settlement, whether open or closed, all details including dates of incidents, filings, settlements, underlying circumstances, subsequent events including patient outcome, professional liability insurer involved, amounts paid and current status.
4. Has your professional liability insurance ever been denied, suspended, canceled or not renewed? . . . . . ☐ Yes ☐ No
5. Considering the essential functions as a practitioner, have you ever suffered or continue to suffer from any communicable health condition that could pose a significant health or safety risk to your patients? . . . . . ☐ Yes ☐ No
6. Have you ever been convicted of a crime (other than a traffic offense), or any plea of nolo contendere, if applicable, or are currently under indictment for an alleged crime? . . . . . ☐ Yes ☐ No
7. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? . . . . . ☐ Yes ☐ No

If your answer to any of the above questions is "YES", please provide full details (attach on a separate sheet, if necessary.)

_____

_____

DDS Name:

6. Office Evaluation

Quality Assurance plays a key role in the success of the Ameritas Network. The items listed below are requirements for participation in our program at each office location and will determine acceptance in the Ameritas Network. Please review and complete this office evaluation section for each office location.

IMPORTANT! ***With my signature, I attest to the accuracy of the responses provided in this document and agree that I will correct all deficiencies identified in this document within 90 days of the date of my signature.***

LOCATION: This Office Evaluation is for: ☐ Location A ☐ Location B ☐ Other Location _____

If you have multiple locations, make one photocopy of this section for each location.

A. Availability / Access

Current Appointment Availability: **Initial:** ____Weeks **Routine:** ____Weeks **Hygiene:** ____Weeks

Average Wait Time in Office: _____Minutes **Average Wait Time in Operatory:** _____Minutes

Does this office provide access for the physically disabled . . . . . ☐ Yes ☐ No

If **yes**, please indicate type of access (check all that apply):

☐ Handicapped parking space is provided ☐ Restrooms have handrails

☐ Office is wide enough for wheelchairs (entry, exam room, restroom)

☐ There are no barriers that may prevent a handicapped/disabled person from receiving a comprehensive exam/service

B. Requirements

Emergency Preparedness

Office has an answering machine or service . . . ☐ Yes ☐ No (1)

Emergencies are handled within 24 hours. . . . . ☐ Yes ☐ No (2)

If no, list emergency contact protocol _____

Medical Emergency Preparedness

Doctor has current CPR training. . . . . ☐ Yes ☐ No (3)

Portable Oxygen or Ambu Bag is available . . . . ☐ Yes ☐ No (4)

Office staff is OSHA trained. . . . . ☐ Yes ☐ No (5)

Hepatitis B vaccine is offered to all back-office employees. . . . . ☐ Yes ☐ No (6)

If no, is a Waiver obtained? . . . . . ☐ Yes ☐ No

If oral surgeon, staff has current CPR training . ☐ Yes ☐ No (7)

If oral surgeon, emergency Drug Kit is current . ☐ Yes ☐ No (8)

Epinephrine: Exp. Date _____

Nitrostat Tabs/Spray: Exp. Date _____

Radiation and Environmental Safety

If X-rays are taken in the office:

Lead Apron is used . . . . . ☐ Yes ☐ No (9)

If no, digital X-rays only . . . . . ☐ Yes ☐ No

If periapical X-ray unit is available, thyroid collar is used . . . . . ☐ Yes ☐ No ☐ Not Available (10)

Sterilization / Disinfection

Method of sterilization ☐ Autoclave ☐ Heat ☐ Chemclave ☐ Statim ☐ Other / Name _____

Spore Testing with (please indicate frequency and company) (11)

Frequency performed

☐ Weekly ☐ Monthly ☐ Other _____

Company

☐ Mesa Labs ☐ SMS ☐ Cottrell Confirm ☐ SPS

☐ Maxitest ☐ SteriCheck ☐ Attest ☐ Bioview

☐ Other _____

Spore results kept in office . . . . . ☐ Yes ☐ No (12)

Instruments are kept in sterilization bags or cassettes until ready to use or stored in a covered area. . . ☐ Yes ☐ No (13)

All instruments and tools are heat sterilized or disposed of between patients:

Handpieces . . . . . ☐ Yes ☐ No (14)

Endodontic Files/Burs . . . . . ☐ Yes ☐ No ☐ N/A (15)

All Instruments. . . . . ☐ Yes ☐ No (16)

If no, cold sterilization is used . . . . . ☐ Yes ☐ No (17)

The Sterilization Room is free from food and drink ☐ Yes ☐ No (18)

Surface disinfection is used between each patient ☐ Yes ☐ No (19)

Suction lines are flushed daily with an antimicrobial agent . . . . . ☐ Yes ☐ No (20)

If oral surgeon, antimicrobial soap is used for handwashing . . . . . ☐ Yes ☐ No (21)

Infectious / Hazardous Waste Disposal

Sharps containers are used for waste disposal . . ☐ Yes ☐ No (22)

Barrier Control

Gloves are used with each patient. . . . . ☐ Yes ☐ No (23)

Gloves are changed between each patient . . . . ☐ Yes ☐ No (24)

Masks are used with each patient when splatter is anticipated . . . . . ☐ Yes ☐ No (25)

Masks and eye protection or full face shields are available for staff. . . . . ☐ Yes ☐ No (26)

Eyewash station is installed and in working order. ☐ Yes ☐ No (27)

Operatories

Equipment is clean . . . . . ☐ Yes ☐ No (28)

Documentation

Health History is completed, signed and dated by patient or legal guardian at 6-month/annual checkup ☐ Yes ☐ No (29)

If general anesthesia is available, appropriate monitoring equipment is present . . . . . ☐ Yes ☐ No ☐ Not Available (30)

Authorization and Release

I consent to the release to Ameritas Life Insurance Corp. and its affiliates ("Ameritas") of information from all state licensing authorities, certification boards, professional liability insurance carriers (including claim histories and loss reports), hospitals, substance-abuse programs, and health-care-related employers about my qualifications, including without limitation, my professional competence and conduct. The information received pursuant to this application or in conjunction with this application will be held in confidence by Ameritas, to the extent permitted by law. I release Ameritas, its associates and any persons or entities providing information to Ameritas or evaluating the information received or provided, from any and all liability, providing their acts were performed in good faith and without malice.

I understand I have the burden of providing adequate information to demonstrate my qualifications. I understand and agree that falsification or material omission on this application will constitute grounds for rejection of my application or immediate dismissal as a provider with Ameritas. I understand and agree that it is my obligation to immediately notify Ameritas if any material changes occur in the information I provided on this form.

By providing the above email address and signing the application where provided below, you are agreeing that if accepted as a member of the Ameritas Network to receive electronic delivery of: (1) disclosures, forms, notices, newsletters and other information we provide from time to time to providers participating on the Ameritas Network, and (2) contract amendments, modifications and other contract-related documents. If applicable law or system limitations prevent Ameritas from delivering certain documents, Ameritas will deliver them as allowed by law. Additionally, I hereby authorize Ameritas to include the email and website address I've provided in Section 1 of this Application as part of my listing on the Ameritas Network Provider directory along with my name and other contact information, unless indicated otherwise. By agreeing to advertise my email address, I verify it is intended for patient communication, regularly monitored, and maintained in a manner consistent with state and federal health privacy law.

I attest that the information contained on this form is correct and complete. I understand and agree that submission of this application does not constitute acceptance or approval, and does not permit me to represent myself as a Provider in the Ameritas Network.

Additionally, I hereby authorize Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York and their agents/representatives to send faxes to the facsimile number(s) listed above in this application. I understand that I may later revoke this fax authorization in writing.

_____
Print Name

X _____ _____
Signature (Owner) Date

Notice: Ameritas will provide written notification of acceptance or denial of your participation in the Ameritas Network. Denials will include the specific reason(s) for non-acceptance.

Please make sure that all questions on this form are answered and completed in their entirety.