Western® Dental

BENEFITS DIVISION

PROVIDER APPLICATION FORM

A Separate Site Application is Required for Each Location

FOR INTERNAL USE ONLY
Provider#:

I. SITE OFFICE INFORMATION

PRACTICE NAME				
ADDRESS				SUITE #
CITY		STATE		ZIP
OFFICE TELEPHONE #	OFFICE FAX #		E-MAIL ADDRESS	
OWNER DENTIST	SS#	TIN	OFFICE MANAGER	
NPI# FACILITY/ SITE				

ISSUE CAPITATION CHECK TO:

☐ Doctor ☐ Practice

PRACTICE TYPE

☐ General Dentist
☐ Specialist
☐ Multi-Disciplinary

II. STAFFING

Indicate the names of all Dentists practicing in this office:

NPI # (DENTIST)	SS or TIN #	FIRST NAME	LAST NAME	SPECIALTY	LICENSE #	YEAR GRADUATED

III. PATIENT MANAGEMENT

Please Indicate Languages Spoken:

☐ English ☐ Chinese ☐ Russian ☐ Vietnamese ☐ Other (specify) ____________________

☐ Spanish ☐ Japanese ☐ French ☐ Tagalog

Please indicate number of new patients/month the Practice can accept without adding additional Dentists:

☐ Less than 50 ☐ 51 -100 ☐ 100+

Please indicate how long a patient must wait for an appointment:

New Patient Exam (Days):

☐ 0-7 ☐ 22-28
☐ 8-21 ☐ 28+

Hygiene Appointment (Days):

☐ 0-7 ☐ 22-28
☐ 8-21 ☐ 28+

Routine Treatment (Days):

☐ 0-7 ☐ 22-28
☐ 8-21 ☐ 28+

Are emergency services available 24 hours per day, 365 days per year? ☐ Yes ☐ No

Do emergency services include the provision of clinical treatment where such treatment is required? ☐ Yes ☐ No

Indicate type of emergency provisions available in your practice:

☐ Associate coverage ☐ Answering Service ☐ Answering machine w/pager ☐ Other ____________________

Please indicate method used in recalling patients on a regular basis:

☐ Letter/Postcard ☐ Telephone Manual ☐ Telephone Automatic ☐ None ☐ Other ____________________

IV. EQUIPMENT MANAGEMENT

Is office equipped with:

☐ X-ray Units ☐ Nitrous Oxide ☐ Portable Oxygen

Are x-ray controls permanently mounted to the walls? ☐ Yes ☐ No

Does radiation equipment meet State inspection/safety requirements? ☐ Yes ☐ No

Are x-ray units currently state certified? ☐ Yes ☐ No

If yes, indicate:

CERTIFICATION #	EXPIRATION DATE

V. COMPUTERIZATION

Do you submit claims electronically? ☐ Yes ☐ No

Do you have Internet access? ☐ Yes ☐ No

VI. FACILITY

Type of parking available

☐ Private Lot

☐ Municipal Lot

☐ Street

Please indicate the number of:

Square feet in practice: ☐ <1000 ☐ 1000-2499 ☐ 2500-5000 ☐ >5000

Seats in reception area: ☐ 1-2 ☐ 3-10 ☐ 11-20 ☐ 21+

Equipped operatories: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

Please indicate days and hours of operation:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

VII. INTERNAL POLICIES

Health education materials are available. ☐ Yes ☐ No

Post Op instructions are written. ☐ Yes ☐ No

Financial arrangements are routinely made. ☐ Yes ☐ No

Treatment plans are routinely presented to patients. ☐ Yes ☐ No

Informed Consent Forms are routinely used. ☐ Yes ☐ No

Patient's records are in the treatment room. ☐ Yes ☐ No

Patients are escorted to and from operatory. ☐ Yes ☐ No

Lead aprons are routinely used. ☐ Yes ☐ No

Emergency medical kit is routinely updated. ☐ Yes ☐ No

Emergency phone numbers are by each phone. ☐ Yes ☐ No

New patients sign complete medical form. ☐ Yes ☐ No

Medical conditions are flagged. ☐ Yes ☐ No

Medical histories are updated regularly. ☐ Yes ☐ No

X-rays are taken at initial exam. ☐ Yes ☐ No

Doctors and assistants are trained in CPR. ☐ Yes ☐ No

VIII. DOCUMENTATION

Please attach copies of the following documents for each provider listed in Section II of this form.

1. Dental License
2. Specialist License (where applicable)
3. DEA Certificate
4. Informed Consent For Treatment Forms and policy
5. Proof of Professional Liability Insurance
6. CPR

Please provide the following:	
Dental License #	
Specialist License #	
DEA Certificate #	

PROFESSIONAL LIABILITY INSURANCE COMPANY		
PROFESSIONAL LIABILITY POLICY #	PROFESSIONAL LIABILITY (EACH CLAIM)	PROFESSIONAL LIABILITY (AGGREGATE CLAIM)

Signature of Owner Dentist

Date