Applicant Name:

Minnesota Uniform Dental Initial Credentialing Application

CREDENTIALING CONTACT INFORMATION (please provide contact information If you would like us to contact someone other than you (the provider) in the event that we have questions related to this credentialing application)

Name: _____ **Phone Number:** _____

Address: _____ **Fax Number:** _____

_____ **E-mail:** _____

_____

This credentialing application is accepted by the following dental plans:

- **Delta Dental of Minnesota**
- **HealthPartners**
- **IM Care**
- **PrimeWest Health**

Instructions

The initial credentialing application and attachments should be typed, legibly printed in black ink, or electronically generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Please mark all non-applicable sections with N/A.

Checklist (please complete)

Current copies of the following documents must be submitted with this application.

- Diploma (if educated outside of U.S. or Canada)
- Malpractice Litigation and Professional Complaints Form (if applicable)
- Malpractice liability insurance face sheet or certificate of insurance

In addition, please verify that you:

- Provide complete addresses wherever indicated, including past employment, and references
- Designate dates by month and year time frames
- Explain all gaps of greater than three months in chronology (Page 4)
- Answer all of the Disclosure Questions on Page 7 and enclosed explanations for affirmative answers
- Sign and date the Attestation Signature and Date statement (Page 7)
- Sign and date the Authorization and Release (Page 9)
- Keep a copy of your completed application for your records

All Information Must Be Printed in Black Ink, Typed or Electronically Generated

Personal Data

Name: _____
Last First Middle Suffix Title

Maiden/Former/Other Name(s):_____ Gender: ☐ Male ☐ Female

Date of Birth:____/____/____ Social Security Number:_____NPI:_____

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language? ☐ Yes ☐ No

If yes, specify languages:_____

Primary or Pending Practice Location

Primary Practice Location/Clinic Name:_____

Address:_____
Street City/State/County Zip Code

Office Phone Number:_____ Fax Number: _____

Federal Tax ID Number:_____ E-mail Address:_____

Type II (facility) NPI: _____

Start date at this location: _____ Specialty in which care will be provided: _____

Additional Practice Location(s) (If additional space is required, attach a separate sheet)

Other Practice Name:_____

Address:_____
Street City/State/County Zip Code

Office Phone Number:_____ Fax Number: _____

Federal Tax ID Number (if different than primary):_____E-mail Address:_____

Type II (facility) NPI (if different than primary):_____

Start date at this location:_____ Specialty in which care will be provided:_____

Other Practice Name:_____

Address:_____
Street City/State/County Zip Code

Office Phone Number:_____ Fax Number: _____

Federal Tax ID Number (if different than primary):_____E-mail Address:_____

Type II (facility) NPI (if different than primary):_____

Start date at this location:_____ Specialty in which care will be provided:_____

Other Practice Name:_____

Address:_____
Street City/State/County Zip Code

Office Phone Number:_____ Fax Number: _____

Federal Tax ID Number (if different than primary):_____E-mail Address:_____

Type II (facility) NPI (if different than primary):_____

Start date at this location:_____ Specialty in which care will be provided:_____

Dental School

(Month and year required)

From

Institution Name: _____

To

Degree Received: ☐ DMD ☐ DDS ☐ Other (ADT / DT / RDH):_____

Street Address: _____

City:_____State:_____Country:_____

Phone Number:_____Fax Number:_____

Note: Please note that not all Dental Plans credential Advanced Dental Therapists (ADT) / Dental Therapists (DT) and Registered Dental Hygienists (RDH). Please verify with the Dental Plans prior to submitting an application.

From

Institution Name:_____

To

Degree Received: ☐ DMD ☐ DDS ☐ Other:_____

Street Address: _____

City:_____State:_____Country:_____

Phone Number:_____Fax Number:_____

Residency/Post-Graduate/ Training (If additional space is required, attach a separate sheet.)

(Month and year required)

From:_____Institution Name:_____

To:

Type of Program/Specialty:_____

Completed Training: ☐ Yes ☐ No If no, expected completion date:_____

If yes, degree received:_____

☐ Certificate ☐ N/A ☐ Other, please explain_____

If not successfully completed, explain:_____

Street Address: _____

City:_____State: _____ Country: _____

Chronological Employment/Practice History (include Military Service) (Additional space is provided on the Chronological Employment / Practice History Addendum, page 10. You may make extra copies of page 10 or attach a separate sheet for additional employment.)

Chronological listing [month/year] of employment/practice history **for the most recent 5 years or from your post-graduate training if that is less than 5 years.** List all experience, including military service and public health, time out of dental practice in pursuit of other business or professional activities, sabbaticals, parenting, personal travel, personal crisis, etc. **LEAVE NO GAPS IN CHRONOLOGY**.

(Month and year required)

From: _____ Organization Name/Activity: _____

To: _____ Reason for Leaving: _____

Street Address: _____

City: _____ State: _____ Country: _____

Phone Number: _____

From: _____ Organization Name/Activity: _____

To: _____ Reason for Leaving: _____

Street Address: _____

City: _____ State: _____ Country: _____

Phone Number: _____

From: _____ Organization Name/Activity: _____

To: _____ Reason for Leaving: _____

Street Address: _____

City: _____ State: _____ Country: _____

Phone Number: _____

From: _____ Organization Name/Activity: _____

To: _____ Reason for Leaving: _____

Street Address: _____

City: _____ State: _____ Country: _____

Phone Number: _____

Explain gaps/interruptions of <u>greater than three (3) months</u> to practice of dental/professional practice (if additional space is required, attach a separate sheet):

From: _____ Explain: _____

To: _____ _____

From: _____ Explain: _____

To: _____ _____

Liability Insurance - Insurance Carrier for Primary and Pending Practice Location

☐ Attach a copy of professional liability insurance coverage (e.g., face sheet/verification of self-insurance) for **primary practice location** It must include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered.

☐ Certificate Pending

Licensure - List all past, current and pending professional licenses.

State	License Number	Date Issued	Expiration Date	License Status
				☐ Active ☐ Inactive ☐ Pending
				☐ Active ☐ Inactive ☐ Pending

Drug Enforcement Administration Registration

Do you currently hold a DEA registration? ☐ **YES** ☐ **NO**

If **YES**:

DEA Number: _____ State: _____ Expiration Date: ____ ____ ____

NOTE: Address on DEA certificate must be in state where you will be practicing as applicable to this application

If **NO:**

☐ DEA certificate is pending: Date application submitted to DEA: ____ ____ ____

☐ List name of the alternate practitioner or practice that will be covering prescriptions on your behalf:

Name: _____

☐ Not required due to scope of practice (i.e. Orthodontics, Pediatric Dentistry, teaching institution)

☐ If an alternate practitioner or practice is not designated (because of scope of practice OR office policy to not prescribe controlled substances), please indicate how you will manage prescribing controlled substances if necessary (i.e. referral to primary care physician, etc.):

_____

Specialty/Subspecialty Certification

☐ I do not hold specialty/subspecialty certification

Certifying Board	Specialty/Subspecialty	Date Certified	Date Recertified	Expiration Date	Cert. Pending
					☐
					☐

Primary Hospital Affiliation (pertinent to Primary or Pending Practice Location listed on page 2)

☐ I do not have hospital affiliation.

(Month and year required)

From: _____ Facility Name: _____

To: _____ Street Address: _____

City: _____ State: _____

☐ Application Pending Admitting Privileges ☐ Yes ☐ No

Other Current Hospital Affiliations

(Month and year required)

From: _____ _____ Facility Name: _____

If hospital changed name, list current name and address

To: _____ Street Address: _____

City: _____ State: _____

☐ Application Pending Admitting Privileges ☐ Yes ☐ No

Insurance Carrier for Primary and/or Pending Practice Location and 5-year insurance history.

Enclose a copy of professional liability insurance coverage (e.g., certificate of insurance, face sheet, or verification of self-insurance) for primary practice location to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered.

Coverage dates:

(Month, day, year required)

Start: _____ Current Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

☐ Certificate Pending Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Please list all insurance policies you have held in the past 5 years, including policies covering Residency and Fellowships.
Specify dates of coverage for each policy. *If additional space is required, complete the Liability Addendum, page 11.*
Additional documentation of insurance coverage may be required.
For coverage provided by the Federal Tort Claims Act, attach a copy of the federal tort letter and provide applicable dates of coverage.
(Month, day, year required)

Start: _____ Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Start: _____ Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

☐ **Check here if you have additional Liability Insurance on attached Liability Insurance Addendum (page 11)**

Please complete and sign this form, attesting to its accuracy. If any of the following questions are answered in the affirmative, provide an explanation by completing the **Disclosure Explanation Form** on the following page.

1. □ Yes □ No Has your **professional license or registration** ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending?

2. □ Yes □ No Has your **professional license or registration** ever been investigated or is it currently being investigated? *If so, provide details to include the reason for the investigation and the results on the following page.*

3. □ Yes □ No Has your **DEA registration** ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?

4. □ Yes □ No Has your **membership, participation, clinical privileges, or employment** ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

5. □ Yes □ No Have you ever voluntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?

6. □ Yes □ No Have you ever involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license or registration?

7. □ Yes □ No Has your **membership or fellowship** in any professional organization or your specialty **board certification** ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?

8. □ Yes □ No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing **board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**

9. □ Yes □ No Has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

10. □ Yes □ No Are there any **charges pending or are you currently charged with**, or have you ever pled guilty or no contest, been indicted or found guilty of a felony, gross misdemeanor, misdemeanor, or other offense?

11. □ Yes □ No Have you ever been charged with, pled guilty or no contest to, or otherwise been subject to allegations of having engaged in **sexual harassment, sexual misconduct, stalking, or any other similar behavior or crime**, or are you aware of any current allegations or charges pending of the same? *Allegations include, but are not limited to, any made by a third party, such as through a lawsuit, restraining order, or other civil proceeding, or allegations made by a colleague to a previous or current employer.*

12. □ Yes □ No Have you ever had any **professional liability claims or lawsuits** brought against you**,** including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments?

13. □ Yes □ No Has your **professional liability carrier** ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?

14. □ Yes □ No Have you ever practiced within your profession without **professional liability insurance?**

15. □ Yes □ No Do you currently have any condition that adversely affects your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent, ethical, and professional manner? *You are not required to disclose a health condition if it is being appropriately treated or otherwise does not affect your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent and professional manner.*

16. □ Yes □ No Do you use any legal/illegal drugs or substances which adversely affect your ability to perform your duties as a member of the healthcare team?

Attestation Signature and Date

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed. I understand that the race, ethnicity, and language information I have provided (or withheld) on this application is optional and will not be used as basis for credentialing decisions or discrimination.

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Signature _____ Date _____

Name _____

CONFIDENTIAL INFORMATION

If you answered **yes** to any of the Disclosure Questions on the previous page, provide an explanation for each by completing the following form. Please attach external documentation of your response as applicable (e.g., statement from an attorney, court records, etc.). Make additional copies of this form if needed.

Applicable Disclosure Question(s): _____ **Date of Occurrence:** _____

Location of Occurrence: *Facility (if applicable)* _____ **State:** _____

Provide a complete explanation regarding the reason you answered the applicable disclosure question(s) in the affirmative.
*Do **not** include name of patient or any other information that may identify a patient.*

Describe outcome, as applicable. ***Note: If responding to disclosure question #12, skip this section and complete next section.***

I*f you answered yes to Disclosure Question #12, complete the following section.*

Describe Outcome of Claim or Lawsuit

Date Filed: _____

CONCLUDED WITH NO PAYMENTS: *(month/year)*

☐ Dropped/Closed Date: _____

☐ Verdict for you Date: _____

☐ Dismissed with prejudice* Date: _____

☐ Dismissed without prejudice** Date: _____

CONCLUDED WITH PAYMENTS: *(month/year)*

☐ Verdict for Plaintiff Date: _____ Amount $ _____

☐ Settled Date: _____ Amount $ _____

PENDING

☐ Filed, pending Date: _____

**Dismissed with prejudice – set aside the lawsuit and deny the right to file another suit on the same claim*

**Dismissed without prejudice – set aside the lawsuit but leave open the possibility of another suit on the same claim*

Represented by Legal Counsel for this lawsuit: ☐ Yes ☐ No - **If yes, provide name and address of counsel.**

Counsel Name _____ Phone _____

Address _____

Insurance company or employer that provided coverage for this claim.

Name _____ Policy# _____

Address _____ Phone _____

I hereby certify that all the information on this form is complete, true and accurate.

Applicant Signature _____ Date _____

Print Name _____ Phone _____

Provider Authorization and Release

(Please read carefully before signing)

I understand and acknowledge that, as an applicant for membership, participation, and/or clinical privileges (hereinafter, referred to as "Participation") at PrimeWest Health hereafter referred to as "Entity"), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics, and any other criteria adopted by the Entity for Participation.

I further acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of the Entity and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation.

I further understand and acknowledge that the Entity, its designated agent(s), and/or other authorized representatives, including, without limitation, the Entity's designated professional credentials verification organization (CVO), collectively referred to as "Agents," will investigate the information in this Application. By submitting this Application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Entity and its Agents as follows:

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize the Entity and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, 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 and authorize such third parties to release such information to the Entity and its Agents.

2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary Information about any disciplinary action taken against me to the Entity and/or its Agents, including, without limitation, the CVO, and as otherwise may be required by law. I hereby further authorize the CVO to release Disciplinary Information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organizations, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition my Participation or impose a corrective action plan; (ii) any other disciplinary actions involving me including but not limited to discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.

3. **Release from Liability**. I hereby further release from liability the Entity and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunities provided by law for peer review activities.

I understand that communication regarding my application may occur via email.

I understand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation at the Entity, or I am a member of Entity's medical or health care staff, or a participating provider of the Entity. I agree to execute another consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide another consent may be grounds for termination or discipline of the Participant by the Entity in accordance with the applicable bylaws, rules and regulations, and requirements of the Entity.

I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Entity and its Agents are done to achieve, maintain and improve quality patient care.

All information provided by me in the Application is true to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of Participation. I understand and acknowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original.

Signature _____ **Date** _____

Printed name _____

Chronological Employment/Practice History Addendum

(Please make as many extra copies as necessary)

(This is an extra copy for your use if needed)

(Month and year required)

From:_____ _____ Organization Name/Activity: _____

To: _____ Reason for Leaving:_____

Street Address: _____

City:_____State:_____Country:_____

Phone Number:_____

From: _ Organization Name/Activity: _____

To: _ Reason for Leaving:_____

Street Address: _____

City:_____State:_____Country:_____

Phone Number:_____

From:_____ _____ Organization Name/Activity: _____

To: Reason for Leaving:_____

Street Address: _____

City:_____State:_____Country:_____

Phone Number:_____

From: _ Organization Name/Activity: _____

To: _____ Reason for Leaving:_____

Street Address: _____

City:_____State:_____Country:_____

Phone Number:_____

Please make additional copies of this Addendum as necessary.

Please list all insurance policies you have held in the past 5 years, including policies covering Residency and Fellowships. Specify dates of coverage for each policy.

For coverage provided by the Federal Tort Claims Act, attach a copy of the federal tort letter and provide applicable dates of coverage.

(Month, day, year required)

Start: ______________ Insurance Carrier Name: ______________________________

Expire: ______________ Address: ______________________________

Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

Name in which policy issued: ______________________________

Policy number (if applicable): ______________________________

Amount of coverage (per occurrence): ______________________________

Amount of coverage (per aggregate): ______________________________

Start: ______________ Insurance Carrier Name: ______________________________

Expire: ______________ Address: ______________________________

Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

Name in which policy issued: ______________________________

Policy number (if applicable): ______________________________

Amount of coverage (per occurrence): ______________________________

Amount of coverage (per aggregate): ______________________________

Start: ______________ Insurance Carrier Name: ______________________________

Expire: ______________ Address: ______________________________

Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

Name in which policy issued: ______________________________

Policy number (if applicable): ______________________________

Amount of coverage (per occurrence): ______________________________

Amount of coverage (per aggregate): ______________________________

Application Addendum

Accepting new patients? ☐ Yes ☐ No Directory Suppress? ☐ Yes ☐ No

Professional/Peer References

List three (3) professional peers who have personal knowledge of your **current (within the past 12 months)** clinical skills, abilities, judgment, professional performance, and clinical competence or have been responsible for professional observation of your work. A *peer* is defined as an individual in the same professional discipline with essentially equal qualifications (MD and DO are considered equivalent; DDS/DMD for DDS/DMD; DPM for DPM; PhD for PhD, etc.) Limit to **one (1) current office associate. Do not include your residency director, fellowship director, relatives, or pending partners.** At least one reference should be in your specialty (and if possible from the same subspecialty). Provide current and complete addresses. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.

Name _____ Title _____

Facility Name _____

Address _____
Street City/State/Country Zip Code

Phone Number _____ Fax Number _____

Email Address _____

Name _____ Title _____

Facility Name _____

Address _____
Street City/State/Country Zip Code

Phone Number _____ Fax Number _____

Email Address _____

Name _____ Title _____

Facility Name _____

Address _____
Street City/State/Country Zip Code

Phone Number _____ Fax Number _____

Email Address _____

Application Attestation Update

The signature blocks below are to be signed ONLY if a previously completed application is being reviewed and updated.

Application Attestation Update

The application was designed so that a practitioner need complete it in its entirety only once. If application is then made to another organization that accepts this Initial Credentialing Application and it has been more than 60 days since the practitioner completed or updated the application, the practitioner may do the following:

- Review the application
- Make any needed modification
- Sign the attestation block below, reconfirming that the application is complete, true, and accurate

Please note: It is particularly important that the Disclosure Questions be reviewed and any changes made with appropriate documentation included.

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true, and accurate.

Signature _____ Date _____

Medicare/Medicaid and Other Government Reimbursement Programs Penalty Statement: This statement is required by Medicare/Medicaid and other government reimbursement programs.

Penalty statement according to the Federal Register dated August 31, 1984 and effective October 1, 1984.

"NOTICE TO ALL PRACTITIONERS RECEIVING MEDICARE/MEDICAID AND OTHER GOVERNMENT REIMBURSEMENT PROGRAM PAYMENTS"

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient as attested to by the patient's attending physician by virtue of his or her signature on the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

Signature_____ Date_____

Name _____

Continuing Education Attestation

Please read the following attestation carefully before signing and dating the statement.

I hereby certify that I have a sufficient number of CE credits to meet the licensure requirements and attest that an appropriate percentage relate to my specialty. I understand that these credits may be audited by an individual facility based on their individual requirements.

Signature _____ Date _____

Name _____

Signature/DEA Verification

Pharmacies are required to maintain signatures and DEA numbers on file for all practitioners who prescribe.

Signature _____ Date _____

Name _____DEA Number _____

Office Address _____Specialty _____

Phone Number _____

Practitioner Gender Information

Gender: ☐ M – Male ☐ F – Female ☐ X – Unspecified or Another Gender Identity ☐ U – Undisclosed

Practitioner Name: _____
Last First Middle Suffix Title

Practitioner NPI: _____

Practitioner Race and Ethnicity

Race and ethnicity (for health plan use only):

The following information is optional and may be used in provider directories to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.

Race (Select all that apply):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other (please specify): _____
- ☐ Prefer Not to Say

Ethnicity

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Prefer Not to Say

*Providing race, ethnicity and/or language information on the credentialing application is entirely optional and refusal to provide this information will **not** subject you to adverse treatment. We do not discriminate or base credentialing decisions on an applicant's race, ethnicity, and language.*

If provided on the credentialing application, the health plan may utilize race, ethnicity and/or language information in provider directories or in internal resources to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.

Check here if you do not wish for your race and ethnicity to be displayed in provider directories: ☐