Provider Application

Instructions

- Type or legibly print in black or blue ink.
- Keep a copy of the application on file for future requests.
- If more space is needed than provided on original application, attach additional sheet(s) and reference the question being answered.
- Please do not use abbreviations.
- **If changes must be made to the completed application, cross out the information and write in the modification; changes must be initialed and dated.**

Additional Documents to Include with Application

- **Practice/Group**
  - A completed, signed, and dated Disclosure of Ownership form with corresponding W-9(s) for each Practice and/or Office Location operating under a different Tax ID.
- **Provider**
  - Copy of Current State License(s)
  - Copy of DEA and/or CSR Certificate if applicable
  - Certificate or Proof of Professional Liability Coverage
  - Curriculum Vitae

Application Submission

Please return completed application and attachments to Argus Dental & Vision, Inc. Attention: Provider Relations

If by mail: 4919 W Laurel Street, Tampa, FL 33607

If by email (Dental): provider.relations@argusdentalvision.com

If by email (Vision): vision.PR@argusdentalvision.com

If by fax (Dental): 813-400-1781

If by fax (Vision): 813-400-4529

Incomplete applications will be returned for completion prior to processing and will delay credentialing

If you have any questions, call Argus's Provider Relations Department at 877-864-0625, Prompt 5.

PROVIDER INFORMATION				
Provider's Name (include suffix; Jr., Sr., III):				
Maiden/Other Name(s) (if applicable):		☐ Owner	☐ Associate	☐ Employee
SSN:	TIN (if different):	DOB (mm/dd/yyyy):		☐ Male ☐Female
Individual NPI:		E-mail:		
Individual Medicaid Number ☐Yes ☐No ☐In Process		Medicaid ID:		
Individual Medicare Number ☐ Yes ☐No ☐In Process		Medicare ID:		
Do you submit claims under you TIN or the Practice? ☐TIN ☐Practice ☐N/A				

PROVIDER TYPE					
☐ Dental	☐ General Dentist	☐ Specialty:	☐ Endo	☐ Perio	☐ Prostho
			☐ Pedo	☐ Oral Surgery	☐ Ortho
☐ Vision	☐Routine Vision ☐ Medical and Surgical ☐ Medical Only ☐ Surgical Only ☐ Optician/ Optical Facility				
	☐Ophthalmologist	☐ Specialty:	☐ Cornea	☐ Glaucoma	☐ Oculoplastic
	☐ Optometrist		☐ Retina	☐ Neuro	☐ Pedo

PROFESSIONAL TRAINING		
Professional School:	Degree:	Year Graduated:
Residency Program (if applicable):	From:	To:
Fellowship or Advanced Training (if applicable):	From:	To:
If Board Certified select certifying board below:	☐ Not Board Certified	

Dentistry	Vision
☐American Board of General Dentistry	☐American Board of Optometry
☐American Board of Endodontics	☐American Board of Ophthalmology
☐American Board of Oral Surgery	☐American Osteopathic Association
☐American Board of Orthodontics	☐American Association of Physician Specialists
☐American Board of Pediatrics	
☐American Board of Periodontology	
☐American Board of Prosthodontics	

LICENSING INFORMATION	Please attach copies of current documents identified below.			
State Licenses:	State:	License Number:	Eff. Date:	Exp. Date:
	State:	License Number:	Eff. Date:	Exp. Date:
	State:	License Number:	Eff. Date:	Exp. Date:
DEA Certificate	Number:	Eff. Date:	Exp. Date:	☐ Not Applicable
Controlled Substance Certificate (CDS)	Number:	Eff. Date:	Exp. Date:	☐ Not Applicable
General Anesthesia Permit	Number:	Eff. Date:	Exp. Date:	☐ Not Applicable
CPR Certificate	Number:	Eff. Date:	Exp. Date:	☐ Not Applicable

PRIVILEGES: ☐Hospital ☐ Ambulatory Surgical Center ☐Admitting Agreement ☐ Not Applicable		
Hospital Name:	Address:	
City:	State:	Zip:
Phone Number:	Contact Name:	
Date Privileges Granted:	Type of Privileges:	

For additional hospitals, please copy, and submit with this application.

WORK HISTORY	In lieu of completing the section below, you may attach a resume or Curriculum Vitae. To be acceptable, Resume or Curriculum Vitae must show last 5 years of employment, including CURRENT EMPLOYMENT. Must be in month/year format.		
Please include **CURRENT EMPLOYMENT**. Must list last five (5) years of employment. Explain any gaps of six (6) months or more on a separate piece of paper.			
Dates To/From (MM/YY - MM/YY)	Employer	Address	Phone

PRACTICE INFORMATION			
Practice Type (Check One): ☐ Solo ☐Partnership ☐Professional Corporation ☐Other _____			
Practice wishes to participate in: ☐ Commercial ☐ Medicaid ☐Medicare Advantage ☐Florida Healthy Kids			
Provider's Name:			
Corporation's Name (if applicable):			
TIN:	Group NPI (NPI-2,if applicable):	Group Medicaid ID (if applicable):	
Practice Name:			
Mailing Address: ☐Check here if multiple billing addresses			
Billing Address:			
Please indicate address to send signed Provider Agreement and Welcome packet:			
Billing Address (if different from above):			
Business Contact:	E-mail Address:	Phone:	Fax:
Credentialing Contact:	E-mail Address:	Phone:	Fax:
OFFICE LOCATIONS Please provide information for only those locations who will participate with Argus.			
Primary Office Location ☐Check here for additional office locations, attach separate page if needed			
Practice Name:			
Complete Address (Street, City, State, Zip code):			
Office Manager:	E-mail Address:	Phone:	Fax:
Practice Name:			
Complete Address (Street, City, State, Zip code):			
Office Manager:	E-mail Address:	Phone:	Fax:

HOURS OF OPERATION

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Name of Provider(s) at this Location, INCLUDING THE APPLICANT. Please provide Medicaid numbers for each provider, as applicable:

1._____ **2.** _____

3._____ **4.** _____

Please complete if different from above Practice Information

Billing Address for this Location:

TIN for this Location (if different, please submit additional W-9):

PATIENT RELATION SERVICES

Languages Spoken by Provider: ☐English ☐Spanish ☐French ☐Other:_____

Language Spoken by Staff: ☐English ☐Spanish ☐French ☐Other:_____

Accepts patients with Developmental Disabilities? ☐Yes ☐No	TTY Available? ☐Yes ☐No	Signing Available? ☐Yes ☐No
Handicap Accessible Office (ADA Compliant)? ☐Yes ☐No	Handicap Parking Available? ☐Yes ☐No	
Provider or Staff CPR Certified? ☐Yes ☐No	Are you accepting new patients? ☐Yes ☐No	Age of Patients? From_____To _____

Do you provide 24-hour coverage? ☐Yes ☐No **24 hour emergency number**: _____

PATIENT PROCEDURE SERVICES Please check all that are applicable

Nitrous Oxide: ☐Yes ☐No	IV Sedation: ☐Yes ☐No	Panoramic X-Ray: ☐Yes ☐No
General Anesthesia: ☐Yes ☐No	Oral Sedation: ☐Yes ☐No	Intraoral X-Ray: ☐Yes ☐No

PROFESSIONAL HISTORICAL DATA QUESTIONNAIRE

The following must be answered by Provider. Please answer all of the following questions ONLY PERTAINING TO THE LAST FIVE (5) YEARS. Any "Yes" response will require a detailed explanation and must be submitted along with the Provider Application.

1.	Have you ever been convicted of a felony or do you have any pending misdemeanor and/or felony charges?	☐ Yes ☐ No
2.	Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned, or otherwise limited?	☐ Yes ☐ No
3.	Have you ever been publicly reprimanded or disciplined by a professional licensing agency or Board?	☐ Yes ☐ No
4.	Has your DEA certification and/or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?	☐ Yes ☐ No
5.	Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited?	☐ Yes ☐ No
6.	Has your participation in Medicare, Medicaid or any other government program ever been limited, expelled, excluded or have you voluntarily excluded yourself from any of these programs?	☐ Yes ☐ No
7.	Have you ever been convicted or pled "nolo contendere" to a criminal offense related to Medicare, Medicaid or any other Federal program?	☐ Yes ☐ No
8.	Has your participation in an HMO and/or an Insurance Company network ever been limited, restricted, suspended or terminated?	☐ Yes ☐ No
9.	In the past five years, up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	☐ Yes ☐ No
10.	Considering the essential function of a practitioner in your area of practice, in the past five years, up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients?	☐ Yes ☐ No
11.	In the past five years and up to and including the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	☐ Yes ☐ No
12.	Are you currently participating or under supervision of a Physician or Recovery Network or applicable program?	☐ Yes ☐ No
13.	Has any malpractice carrier made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf in the past five years or are any medical malpractice suits pending against you?	☐ Yes ☐ No
14.	Are you currently uninsured for professional liability (malpractice insurance) coverage?	☐ Yes ☐ No
15.	Has your malpractice/professional liability insurer placed conditions or restrictions on your coverage or ability to obtain coverage in the past ten years?	☐ Yes ☐ No

PROVIDER ATTESTATION, AUTHORIZATION, AND RELEASE OF INFORMATION FORM

I authorize Argus Dental & Vision, Inc., and its subsidiaries, affiliates, successors, employees, agents, authorized representatives, and third parties (hereinafter "ADV"), to consult with hospitals, members of hospital medical staffs, professional liability carriers, managed care organizations and other persons or entities to obtain information concerning my professional credentials and qualifications, including without limitation my professional competence and conduct.

I understand and agree that any misstatement or material omission in this application will constitute grounds for rejection of my application or summary dismissal as a participating provider in any and all managed care products or plans maintained or managed by ADV. If any material changes occur in the information I have provided in this application making such information no longer correct and complete or affecting my professional status, I understand and agree that it is my obligation to notify ADV within ten (10) days of said occurrence.

I release ADV and any and all persons or entities providing information about me to ADV, from any and all liability connected with or arising from the release of such information, provided that such party(ies) was(were) acting in good faith without malice. I further release ADV from any and all liability for its acts performed in good faith and without malice in evaluating my application and any decisions related to my application or credentialing status.

I understand that completion and submission of this application and Attestation and Release of Information Form ("Release") does not automatically grant me membership or participating status with Argus Dental & Vision, Inc.

I attest that the information in this application is complete, accurate, and current. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Provider Signature (NO SIGNATURE STAMP)	Date
Printed Name:	

Additional Office Locations Please provide information for only those locations who will participate with Argus.			
Practice Name:			
Complete Address (Street, City, State, Zip code):			
Office Manager:	E-mail Address:	Phone:	Fax:

Practice Name:			
Complete Address (Street, City, State, Zip code):			
Office Manager:	E-mail Address:	Phone:	Fax:
Practice Name:			
Complete Address (Street, City, State, Zip code):			
Office Manager:	E-mail Address:	Phone:	Fax:
Practice Name:			
Complete Address (Street, City, State, Zip code):			
Office Manager:	E-mail Address:	Phone:	Fax:
Practice Name:			
Complete Address (Street, City, State, Zip code):			
Office Manager:	E-mail Address:	Phone:	Fax: