

Provider Application

Instructions

- Please type directly in the fields below.
- 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

Mailing address: 4919 W Laurel Street, Tampa, FL 33607

Email: provider.relations@argusdentalvision.com

Fax: 813-400-1782

****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)		First Name	Middle Initial	Last Name
Maiden/Other Name(s) (if applicable):		<input type="checkbox"/> Owner	<input type="checkbox"/> Associate	<input type="checkbox"/> Employee
SSN:	TIN (if different):	DOB (mm/dd/yyyy):		<input type="checkbox"/> Male <input type="checkbox"/> Female
Individual NPI:		E-mail:		
Individual Medicaid Number <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Process		Medicaid ID:		
Individual Medicare Number <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Process		Medicare ID:		
Do you submit claims under your TIN or the Practice? <input type="checkbox"/> TIN <input type="checkbox"/> Practice <input type="checkbox"/> N/A				

PROVIDER TYPE					
<input type="checkbox"/> Dental	<input type="checkbox"/> General Dentist	<input type="checkbox"/> Specialty:	<input type="checkbox"/> Endodontist	<input type="checkbox"/> Periodontist	<input type="checkbox"/> Prosthodontist
			<input type="checkbox"/> Pediatric Dentist	<input type="checkbox"/> Oral Surgeon	<input type="checkbox"/> Orthodontist
<input type="checkbox"/> Vision	<input type="checkbox"/> Routine Vision <input type="checkbox"/> Medical and Surgical <input type="checkbox"/> Medical Only <input type="checkbox"/> Surgical Only <input type="checkbox"/> Optician/Optical Facility				
	<input type="checkbox"/> Ophthalmologist	<input type="checkbox"/> Specialty:	<input type="checkbox"/> Cornea	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Oculoplastic
	<input type="checkbox"/> Optometrist		<input type="checkbox"/> Retina	<input type="checkbox"/> Neuro	<input type="checkbox"/> Pediatric

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: <input type="checkbox"/> Not Board Certified		
<u>Dentistry</u> <input type="checkbox"/> American Board of Endodontics <input type="checkbox"/> American Board of Oral Surgery <input type="checkbox"/> American Board of Orthodontics <input type="checkbox"/> American Board of Pediatrics <input type="checkbox"/> American Board of Periodontology <input type="checkbox"/> American Board of Prosthodontics	<u>Vision</u> <input type="checkbox"/> American Board of Ophthalmology <input type="checkbox"/> American Osteopathic Association <input type="checkbox"/> American Association of Physician Specialists	

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:	<input type="checkbox"/> Not Applicable
Controlled Substance Certificate (CDS)	Number:	Eff. Date:	Exp. Date:	<input type="checkbox"/> Not Applicable
General Anesthesia Permit	Number:	Eff. Date:	Exp. Date:	<input type="checkbox"/> Not Applicable
CPR Certificate	Number:	Eff. Date:	Exp. Date:	<input type="checkbox"/> Not Applicable

PRIVILEGES: <input type="checkbox"/> Hospital <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Admitting Agreement <input type="checkbox"/> 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): <input type="checkbox"/> Solo <input type="checkbox"/> Partnership <input type="checkbox"/> Professional Corporation <input type="checkbox"/> Other _____			
Practice wishes to participate in: <input type="checkbox"/> Commercial <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Florida Healthy Kids			
Provider's Name:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Corporation's Name (if applicable):			
TIN:	Group NPI (NPI-2, if applicable):	Group Medicaid ID (if applicable):	
Practice Name:			
Mailing Address:			<input type="checkbox"/> Check here if multiple billing addresses
Billing Address:			
Address (or email) 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 <input type="checkbox"/> 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:
URL for Practice Website:			

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			Electronic Health/Medical Records in office? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Languages Spoken by Provider: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Other: _____						
Language Spoken by Staff: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Other: _____						
Accepts patients with Developmental Disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No		TTY Available? <input type="checkbox"/> Yes <input type="checkbox"/> No		Sign Language Available? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Accepts patients with Behavioral Health Issues? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Handicap Accessible Office (ADA Compliant)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Handicap Parking? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Staff CPR Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Age of Patients? From _____ To _____		
Do you provide 24-hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No 24 hour emergency number: _____						
PATIENT PROCEDURE SERVICES Please check all that are applicable						
Nitrous Oxide: <input type="checkbox"/> Yes <input type="checkbox"/> No		General/Deep Sedation: <input type="checkbox"/> Yes <input type="checkbox"/> No		Panoramic X-Ray: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Conscious Sedation: <input type="checkbox"/> Yes <input type="checkbox"/> No		Pediatric Conscious Sedation: <input type="checkbox"/> Yes <input type="checkbox"/> No		Intraoral X-Ray: <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever been publicly reprimanded or disciplined by a professional licensing agency or Board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has your DEA certification and/or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have you ever been convicted or pled "nolo contendere" to a criminal offense related to Medicare, Medicaid or any other Federal program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Has your participation in an HMO and/or an Insurance Company network ever been limited, restricted, suspended or terminated?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Are you currently participating or under supervision of a Physician or Recovery Network or applicable program?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Are you currently uninsured for professional liability (malpractice insurance) coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: