DENTAL CENTER & GENERAL DENTIST

ADD ON PACKET ALL ZONES

(602) 841-3494 - 1-800-809-3494 - Fax (602) 589-0417
Corporate Office: Phoenix, Arizona
Mailing Address: PO Box 54277, Phoenix, AZ 85078
Website: www.SavonDentalPlan.com
Email: providerservices@SavonDentalPlan.com

Credentialing Check List

PLEASE MAKE SURE THAT YOU ARE ENCLOSING ALL OF THE FOLLOWING ITEMS

FOR EACH DENTAL CENTER

[ ] The COMPLETED two (2) page CENTER PROFILE

*PLEASE NOTE: **If you have more than one (1) dental center, the two (2) page Center Profile is required for each center. Copies of these page are permissible***

FOR EACH PROVIDER

[ ] The COMPLETED one (1) page PROVIDER PROFILE

[ ] PROFESSIONAL LIABILITY INSURANCE POLICY NUMBER AND EXPIRATION DATE

[ ] STATE DENTAL LICENSE NUMBER AND EXPIRATION DATE

[ ] DEA CERTIFICATE LICENSE NUMBER AND EXPIRATION DATE

*PLEASE NOTE: **Please submit separate credentialing information for each provider at your facility. Copies of this page are permissible***

Center Profile

Please Tell Us About Your Office

What is the name of your practice?____

What is the physical address of the Office?____

City:________________________ State:__________ Zip Code:____________________

What is the office phone number?(_____)______-____________ Fax Number?(______)_______-________________

What is the name of your office manager or appointment coordinator?____

Office Manager's email address: ____

Do you have a Web Site? [ ] Yes [ ] No If yes please give us your web address: www.________________________

If you have a web site would you like a link from our dentist list to your web site? [ ] Yes [ ] No

Is your office in a Metropolitan Area (over 100,000 people) [ ] Yes [ ] No (If no) miles from a Metro Area?_________miles

Are languages other than English spoken in your office? [ ] Yes [ ] No (if yes, please specify)________________________

Is the mailing address the same as the physical address? [ ] Yes [ ] No (If no, please give us the mailing address below).

Address:________________________City:________________State:________Zip:____________

Please Tell Us About Your Operatories and Patient Capacity

How many operatories do you have?______________ How many assistants do you have?________________

Do you have a hygiene department? [ ] Yes [ ] No (if yes) How many hygientists do you have?______________

How many additional patients is your office willing to accommodate on a monthly basis? 10-20 21-50 51-70 71-90 91-100 over 100
(please circle the one that applies)

Please Tell Us About Options and Special Equipment that you have
(please check all that apply to your office)

[ ] Nitrous Oxide	[ ] Ultra Sonic Cleaning	[ ] Laser	[ ] Electro Surge	[ ] IV Sediation
[ ] Oral Sedation	[ ] Prophy Jet	[ ] Denta Cam	[ ] K.C.P. 2000	[ ] Brite Smile/Zoom (etc)
[ ] High Speed Endo (ie Root ZX)	[ ] Digital X-Ray	[ ] Cavitron	[ ] Children Sedation	[ ] On site denture Lab
[ ] On site Crown & Bridge Lab	[ ] Panoramic x-ray machine	[ ] Diode Laser	[ ] CAD/CAM (cerec)	[ ] 3D Imaging

[ ] Other (please explain):____

Center Profile

Please Tell Us What Days and Hours You are Open

Days Open: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday

Office Hours: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Please Tell Us About Your Payment Policy

Please check the credit cards that you accept: [ ] Mastercard [ ] Visa [ ] American Express [ ] Discover

Do you accept any other credit cards? [ ] Yes [ ] No (if yes, please specify)______________________________

Plese check any of the following other forms of payments that you make available to patients

[ ] Personal Checks [ ] DentaCharge [ ] United Surgical [ ] Care Credit [ ] "In house" financing

[ ] Payment plans available through a finance company

[ ] Other (please explain):______________________________

Equipment Sterilization and Infection Control

Do you sterilize your instruments in office? [ ] Yes [ ] No (if yes) Type: [ ] Autoclave [ ] Chemclave [ ] Statem [ ] Steam [ ] Cold [ ] Other

Do you sterilize your handpieces in office? [ ] Yes [ ] No (if yes) Type: [ ] Autoclave [ ] Chemclave [ ] Statem [ ] Steam [ ] Cold [ ] Other

Do you spore test your sterilization unit? [ ] Yes [ ] No (If yes) how often? [ ] Daily [ ] Weekly [ ] Monthly [ ] Other

If other or no is checked for any of these questions please explain:______________________________

Personal Sterilization and Infection Control that is Used in this Office

In the Operatory, Do you wear: Mask [ ] Yes [ ] No Gloves [ ] Yes [ ] No

Eye Protection [ ] Yes [ ] No [ ] As Needed Protective Clothing [ ] Yes [ ] No [ ] As Needed

Emergency Control Procedures

Is your office equipped with Oxygen [ ] Yes [ ] No Is your office equipped with a Blood Pressure Device [ ] Yes [ ] No

Is your office equipped with a Defibrillator [ ] Yes [ ] No Does your office have at Least 1 C.P.R. Certified Person [ ] Yes [ ] No

Compliance Procedures

Does your office Meet O.S.H.A. Standards [ ] Yes [ ] No Does your office Have a Written Infection Control Policy [ ] Yes [ ] No

Does your office Have a Written Hazard Control Policy [ ] Yes [ ] No Does your office have a written H.I.P.P.A. policy [ ] Yes [ ] No

Is your office able to accommodate patients with Disabilities (Special question for our disabled members) [ ] Yes [ ] No

Office Philosophy

Please briefly describe your personal practice philosophy or practice emphasis:______________________________

____

Provider Profile *(A separate profile is required for each provider)*

Please type or print clearly - All information is required unless noted otherwise

What is your name?____D.D.S. or D.M.D. Date of Birth_____/_____/_______

Emergency or Cell Phone Number: (______)______________ What is your EMAIL address?_______________________________________

What Dental College did you graduate from?____In What Year?__________

What is your License Number?____________________________ State:_________ When does it expire?____/____/20______

Who is your Professional Liability Insurance Carrier?____

What is your Policy Number?____ When does your policy expire?____/____/20______

What is your D.E.A. Number?__________________________________ When does it expire?____/____/20______

What is the name of your practice?____

Do you have any Dental Board problems that we should know about? [ ] Yes [ ] No (if yes; please use additional paper to explain)

NOTE: A yes answer to the above question DOES NOT automatically disqualify you from particiaption in our plan.

Skill comfort rating: On a scale of 0 - 10

0- means that you DO NOT perform the procedure

10 - means that you DO perform the procedure including very difficult cases

With this in mind, please rate your comfort and skill level in the following fields:- (please circle one number for each field)

Orthodontics	0	1	2	3	4	5	6	7	8	9	10
Endodontics	0	1	2	3	4	5	6	7	8	9	10
Oral Surgery	0	1	2	3	4	5	6	7	8	9	10
Periodontics	0	1	2	3	4	5	6	7	8	9	10
Pedodontics	0	1	2	3	4	5	6	7	8	9	10
Prosthodontics	0	1	2	3	4	5	6	7	8	9	10
T.M.J.	0	1	2	3	4	5	6	7	8	9	10
Implants	0	1	2	3	4	5	6	7	8	9	10

Optional information:

What is your Personal Mailing Address?____

City:______________________________________ State:________ Zip Code:__________Personal Phone Number? (_____)___________________

All information in this profile is confidential and remains the property of Savon Professional Services, Inc., and Savon Dental Plan.® No information contained herein may be released without the express written permission of the provider listed herein.