

CREDENTIALING CHECKLIST

Please complete all sections of the Credentialing package. Applications submitted with incomplete and/or missing information will delay the credentialing process. The **Dentist's Signature** is required. Faxed, scanned or emailed forms are acceptable. Stamped signatures are not accepted.

☐ **Application to Join Our Dental Networks**

Clearly print or type information in **each** section of the form with indication *Not Applicable* (N/A) where appropriate.

Provide work history for the past five (5) years in month and year format; with explanations of any gaps of more than six weeks.

Provide explanations for any **Yes** responses to the Practice History or Health Status Questions on page 3 of the application.

Indicate Yes or No regarding **Medicare Participation**

Sign & Date page 4 of the application and return with the **Dentist's Signature** as required.

☐ **Participating Provider Agreement:**

Complete, sign, and date page 8. Participating Provider Agreements are not valid without the Dentist's signature, Name/Title, Date, Address, Tax ID Number and provider's Type 1 NPI for each location. Stamped signatures are not accepted. Include your Type 1 NPI Number.

We will only accept Type 1 NPI number on page 8. All Type 2 NPI Numbers should be listed on page 9 Appendix B with the location and tax identification number.

Include your dental license number.

Appendix B: Locations Covered by the Agreement:

If you practice in additional locations, or your practice has multiple locations, please fill out Page 9 B-1 Locations Covered by the Agreement, with Type 2 NPI and Tax Identification number(s) if different and return with the Agreement. Use additional sheets if needed.

☐ Sign and date all fields on **Signature Waiver** form

☐ **IRS Form W-9:** Complete, sign and return, with the practice information.

Photocopies of the following:

- ☐ Hawaii Dental License
- ☐ Specialty Board Certificate or completion of residency from an accredited school (if applicable)
- ☐ National Provider Identifier (NPI) – forward a copy of your confirmation (e.g. letter, email, etc) from the NPI Enumerator.
- ☐ **License Certificate of Malpractice Insurance** (Professional Liability Certificate) which specifies the minimum \$1 million per occurrence; \$3 million aggregate. (*Copy of insurance invoice or binder is not acceptable*).
- ☐ Federal DEA certificate (if applicable)
- ☐ State narcotic certificate (if applicable)

(Documents that expire prior to the credentialing meeting are not acceptable.)

Any questions may be directed to **DentalProviderRelations@bshi.net**. Please allow 60-90 days for completion of the Credentialing process. A Welcome letter will be sent to you following conclusion of the credentialing process.

Submit complete Credentialing Application Packages using **any** of the following methods:

Mail To: HMSA Dental
Provider Relations
P.O. Box 1320
Honolulu, HI 96807-1320

Email To: DentalProviderRelations@bshi.net
Fax To: (808) 538-8996