



Provider Application Instructions

Please complete the enclosed application and submit in the provided envelope or fax to 212.688.9708 for faster processing along with all of the following materials:

- Completed application form
- Signed DentalSave provider agreement
- Current copy of state license(s)
- Current copy of DEA certificate
- Current copy of malpractice insurance

Please allow 2 weeks for processing. Your listing will appear on our website, DentalSave.com within one week after processing is completed. It will be published in the next printing of our Directory of Dentists.

Questions? Please call 800.828.2222

I. OFFICE INFORMATION

A. PRACTICE INFORMATION

Dentist Name _____

Practice Name _____

Address _____ Suite _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Email _____ URL/Website _____

TIN Number _____ NPI Number _____

Office Manager _____ Phone _____

B. PRACTICE FEATURES

Specialties Available: General Oral Surg Pedo Perio Endo Ortho Prosth

Language(s) Spoken other than English: _____

Handicap Access Yes No Hygienist Yes No
 Lab on Premises Yes No Medicaid Accepted Yes No
 Financing Yes No Willing to Treat Children Yes No

Hours of Operations

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

C. FEE SCHEDULE

Please provide the current Fee charged for these procedures

Code	Description	Fee	Code	Description	Fee
D0150	Comprehensive Oral Evaluation		D4341	Periodontal Scaling	
D1110	Prophylaxis - Adult		D2392	Composite - Posterior Two Surfaces	
D0210	Intraoral - Complete Series		D2750	Crown	
D3330	Molar Root Canal		D5120	Complete Denture - Mandibular	

To enroll additional locations please copy this form and fill a separate form for each office.

II. DENTIST INFORMATION

Please complete a separate form for each dentist

A. GENERAL INFORMATION

Name _____
First M Last

Date of Birth _____ Gender Male Female

Languages spoken other than English _____

Specialty: General Oral Surg Pedo Perio Endo Ortho Prosthodontics

B. EDUCATION & TRAINING

Dental School Attended _____ Year of graduation _____

Degree Attained _____

Specialty School Attended _____ Year of graduation _____

Post Graduate Education/Training Completed _____

C. BOARD ELIGIBILITY/CERTIFICATION

Are you board certified Yes No

Are you board eligible Yes No

Recertification required Yes No If yes, recertification date _____

D. LICENSES INFORMATION

(please enclose a copy with your application)

Dental License 1 Number _____ State _____ Expiration Date _____

Dental License 2 Number _____ State _____ Expiration Date _____

DEA License Number _____ Expiration Date _____

Has your license(s) ever been revoked or suspended? Yes No

If yes, Please submit an explanation(s)

E. PROFESSIONAL LIABILITY INFORMATION

(please enclose a copy with your application)

Name of Carrier _____

Policy Number _____ Expiration Date _____

Liability Per Occurrence/Aggregated Amount _____

Have you ever received an adverse decision in a malpractice case? Yes No

If yes, please submit an explanation