

FACILITY APPLICATION

Managed Dental Care Network

For Multiple Office Locations: Please complete one Managed Dental Care Network Facility Application for each office location. Please complete each section of this application in full.

Please complete the following information as you would like it listed in our Provider Directory.

SECTION 1: Office Information

Name of Practice

Facility Location Address

Website

City

County

State

Zip

Telephone

Fax

Office Email

NPI Level 2 (Group)

Mailing Address (if different)

City

State

Zip

Business Contact / Office Manager

Title

Telephone

Contact Email

Owner Information

Office owned by:

- ☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C = C corporation, S = S Corporation, P = Partnership) ☐ Other

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

If Other, explain

If Incorporated, please provide the corporation name

Owner of Practice (as appears on tax return)

Owner's DOB

SSN

Tax ID #:

Is owner of practice licensed to practice dentistry? ☐ Yes ☐ No

State(s)

State Dental License #

Expiration Date

Name of Medicaid Dentist on Staff

Medicaid Provider #

SECTION 1 (cont'd): Office Information

Owner Information

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open:							
Lunch:							
Close:							

Staff Information

	FT	Number of Days
Number of General Dentists		
Number of Hygienists		
Number of Assistants		
Number of Front Office / Receptionists		
List Specialties offered		

Language Assistance Program

List all languages other than English spoken in the office

By Dentist(s) _____

By Staff _____

California Language Assistance Program

	Yes	No
Is Language Assistance Program availability posted in the reception area?	☐	☐
Is notification of availability of translation and interpretation available in the chart registration documents?	☐	☐
Member's decision to accept or decline the offer of language assistance is documented in the chart?	☐	☐
Member's preferred language is noted in the chart documents?	☐	☐
How are requests for translation and interpretation handled?		
☐ Language Line	☐ Other. If Other, please explain: _____	

SECTION 1 (cont'd): Office Information

Plan Participation and Experience

List all managed care programs in which the office currently participates: _____

Are you a MetLife PDP (PPO) provider?

☐ Yes

☐ No

Patient Safety and Office Operations

Please answer the following questions. If No, please provide explanation

	Yes	No	
1. Does your office comply with OSHA standards by having written and posted protocols?	☐	☐	
2. Does your radiography equipment meet government-regulated standards? # of radiography machines? _____ Please include a copy of radiology certificate for each x-ray unit (if applicable).	☐	☐	
3. Personal Protective Equipment (gloves, mask, glasses, gowns)?	☐	☐	
4. Weekly spore testing of each sterilizer unit (with log book)?	☐	☐	
5. Logs for cold sterilization and disinfectant materials?	☐	☐	
6. Does your office use barrier techniques to prevent cross contamination?	☐	☐	
7. Do you sterilize your handpieces between each patient?	☐	☐	
8. Does your office have portable oxygen with positive pressure and are staff members trained in its use?	☐	☐	
9. Does your office have and use lead aprons along with cervical collars?	☐	☐	
10. Do you and/or any members of your clinical staff have CPR training and certification?	☐	☐	
11. Are hazardous waste disposal procedures in accordance with state and local laws?	☐	☐	
12. Do you have a medical emergency kit with all drugs current?	☐	☐	
13. Are billing and medical records secured at all times (HIPAA compliant)?	☐	☐	
14. Are your hours of operation visible to patients or provided by staff?	☐	☐	
15. Would you have any objection to a scheduled office visit by our Dental Director, dental auditor or Network Development (provider relations) staff member?	☐	☐	
16. Does your office use a patient-signed treatment plan and/or signed written consent form for some or all procedures?	☐	☐	
17. Do you offer multiple treatment options when appropriate?	☐	☐	
18. Do you use a financial consent process whereby patient sign approval for a chosen treatment plan that may include non-covered or optional services?	☐	☐	
19. Member eligibility verification accepted by (check all that apply):			
☐ Roster	☐ Telephone	☐ Fax	☐ Web

SECTION 2: Practice Information

Emergency Coverage

NOTE: Emergency 24/7 after-hours coverage to a live person, or referral to an on-call person or 24/7 reasonable, timely, same-day call back is required for network participation.

☐ Answering Service ☐ Pager/Cell #: _____ ☐ Other: _____

If Other, please explain: _____

Current Appointment Wait Time

Initial Visit: _____ weeks Routine ongoing care visit: _____ weeks
Recall Visit: _____ weeks Hygienist Visit: _____ weeks
Average wait time in waiting room prior to seeing dentist: _____ minutes Do you have a recall system in place? ☐ Yes ☐ No
If Yes, Type: _____

Type of Practice Management system used in your office: _____

Total number of patients currently in practice: _____ Will you accept new patients? ☐ Yes ☐ No

Maximum number of patients your practice can accept: _____ Number of operatories: _____

Does your office have/provide the following? (Please check all that apply)

- | | | |
|--|---|---|
| ☐ Panoramic x-ray unit | ☐ Nitrous oxide (with scavenger) | ☐ IV sedation |
| ☐ General anesthesia | ☐ Wheelchair accessibility | ☐ Provided parking |
| ☐ Adm. by contracted provider | ☐ Non-intravenous conscious sedation | |
| ☐ Adm. by non-contracted provider | | |

Sterilization Methods (check all that apply):

- ☐ Autoclave (steam) ☐ Chemiclave ☐ Dry Heat ☐ Cold Sterile ☐ Other

If Other, please explain: _____

General Dentistry Patient Care Services Offered (check all that apply):

- | | | |
|--|--|--|
| ☐ Anterior root canals | ☐ Periodontal surgery | ☐ Pediatric dentistry (children limited to _____ years of age or older) |
| ☐ Bicuspid root canals | ☐ Implant Placement (surgical) | ☐ Oral Cancer screening |
| ☐ 1 st molar root canal | ☐ Implant supported restorations (crowns, retainers, bars, anchors) | ☐ Amalgam restorations |
| ☐ 2 nd molar root canals | ☐ Fixed bridges | ☐ Anterior and Posterior Composite restorations |
| ☐ Apical surgery | ☐ Removable partial dentures | ☐ Sealants |
| ☐ Root canal re-treatment | ☐ Full denture services | ☐ Cast metal crowns |
| ☐ Surgical extractions of erupted teeth | ☐ Orthodontic therapy | ☐ Porcelain fused to metal crowns |
| ☐ Soft tissue impaction removal | ☐ Risk Assessments (e.g. CAMBRA) | ☐ All-porcelain crowns (e.g. CEREC, Zirconia, etc.) |
| ☐ Partial tissue impaction removal | ☐ Pediatric Dentistry age 0-2 infant oral exam with caregiver | |
| ☐ Full bony impaction removal | | |
| ☐ Scaling/Root planing | | |

Please list any routine dental procedures you do not perform in the office (or routinely refer to a specialist):

SECTION 3: Checklist

Please complete this checklist and return it with the requested documentation below.

NOTE: All applicable supporting documents must accompany the application in order to begin the contracting and credentialing process.

- ☐ NPI 1 and/or NPI 2 provided for each contracting provider
- ☐ Signed Provider Contract(s) for each provider at the facility
- ☐ Signed and Completed Managed Dental Care Facility Application
- ☐ Completed Language Skills Self-Assessment Form for each member of your staff that provides language translation or interpretation services (California ONLY)
- ☐ Completed W-9 Form (Legal Entity)
- ☐ Business Card
- ☐ Copy of Bill of Sale/Transfer of Ownership (if applicable)
- ☐ Signed Fee Schedules (if applicable)

Thank you. We look forward to working with you and your staff.

You have the right to review the information utilized by us in processing your application.

Please send your request in writing to the address below. A Statement of Credentialing Program Provider Rights is included with the application packet. If you have any questions regarding the application process, please contact us at:

MetLife Network Development Department
PO Box 2822
Laguna Hills, CA 92654-2822
800.635.4238

