AppCentral User Guide For Providers

DentaQuest®

What is AppCentral?

AppCentral is an Online Enrollment and Credentialing submission tool

Why use AppCentral?

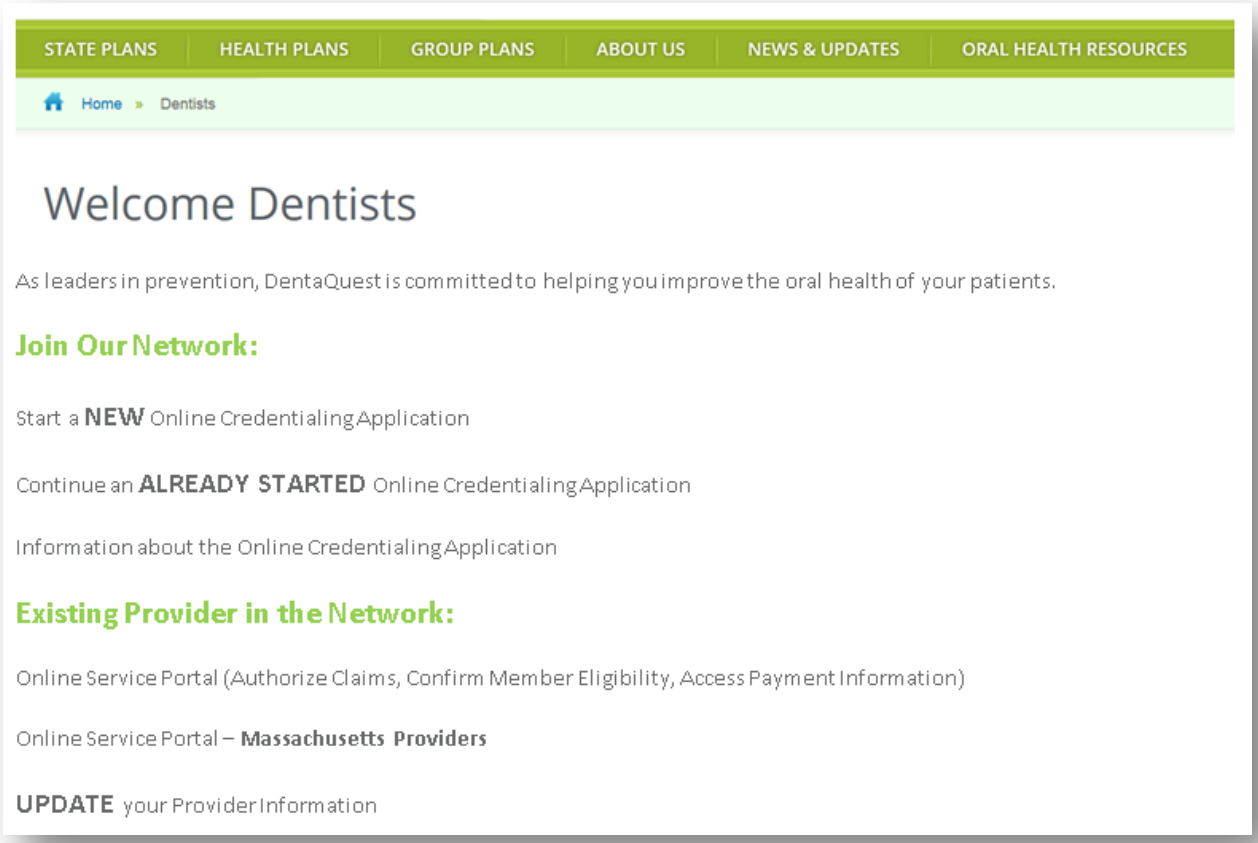
- It's an easier, faster way to get your enrollment and credentialing submitted right the first time.
- It saves you time, and helps to ensure your information is entered quickly, correctly, and completely.
- You will receive status update emails throughout your application process.
- It's an easy-to-use tool that walks you through all required information.
- It promotes faster Credentialing Turnaround Times.
- It provides the providers access to view archived application submissions.
- It's a safe and secure information collection and transmission tool.
- It enables support Staff to see what you see in real-time.
- Pre-Populated Recredentialing Application (coming soon)

Helpful hints before you get started:

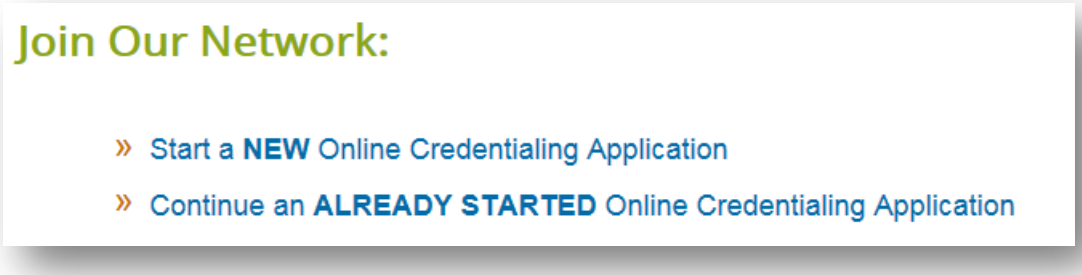
- Registration: When you register an account, the account will be unique to each provider. **Please ensure the account name you register with is the applicant's name**. Once you are registered you will be able to enter a credentialing contact name within the credentialing application. If you are submitting applications for multiple providers, you will create unique accounts for each provider
- Email addresses: an email address is required to register with Application Central. When you create your account as a new provider you can provide two email addresses:
    - **Personal Email (Required):** Used to send a personalized link to access your credentialing application and status updates throughout the credentialing process. When Recredentialing is due (typically every 36 months), this email is used to send the link to complete your application.
    - **Credentialing Email (Not Required):** This email will <u>not</u> receive the link to log-into your personalized credentialing application, but will receive all status updates and requests for additional information where applicable.

Getting Started

1. Visit http://www.dentaquest.com/dentists/



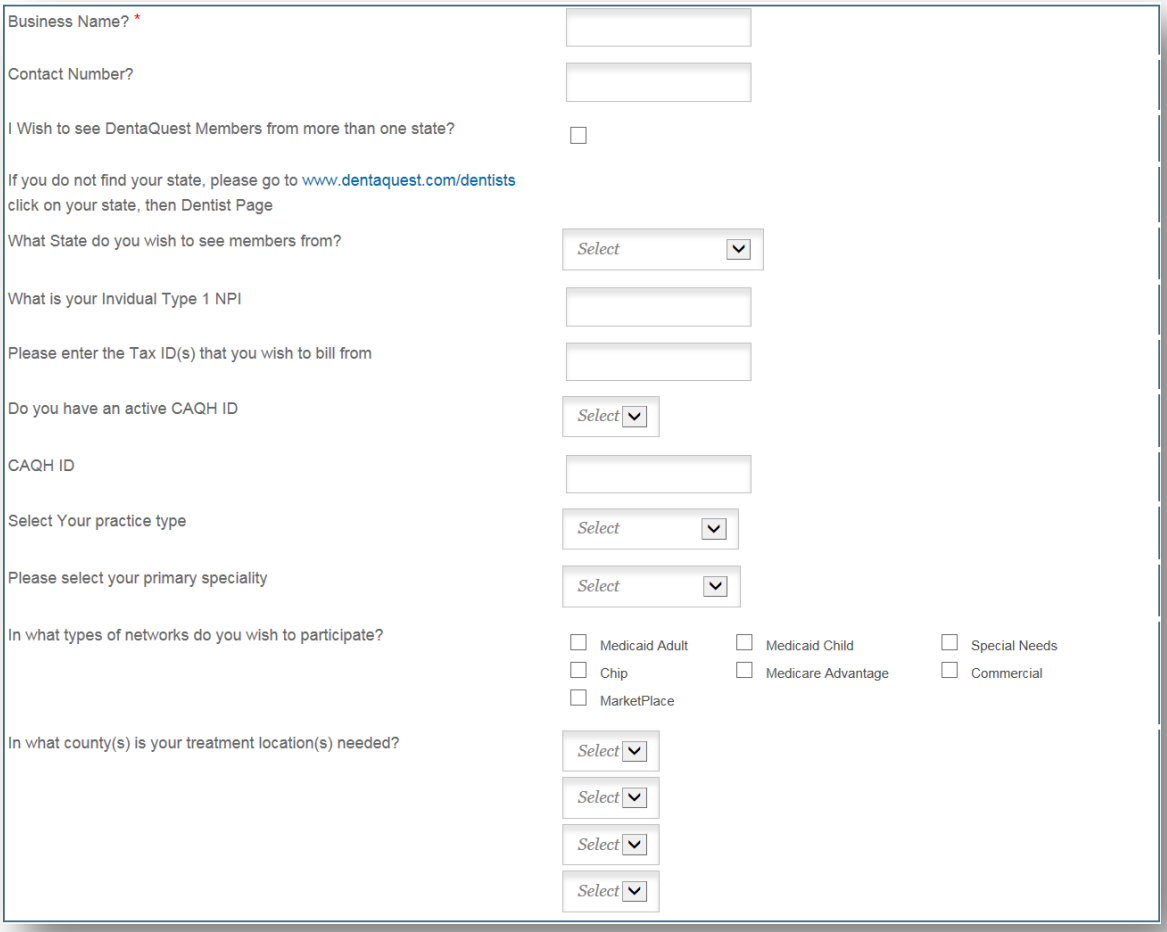
2. Click Join Our Network



3. For new users, click on » Start a **NEW** Online Credentialing Application
4. For existing users, click on » Continue an **ALREADY STARTED** Online Credentialing Application

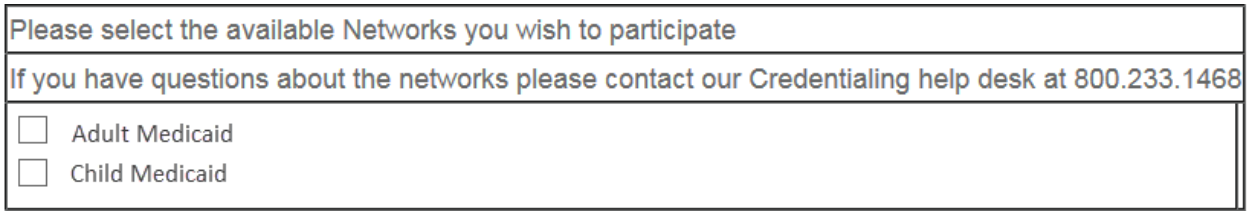
New Online Credentialing Application

1. Fill in the Provider Enrollment Form



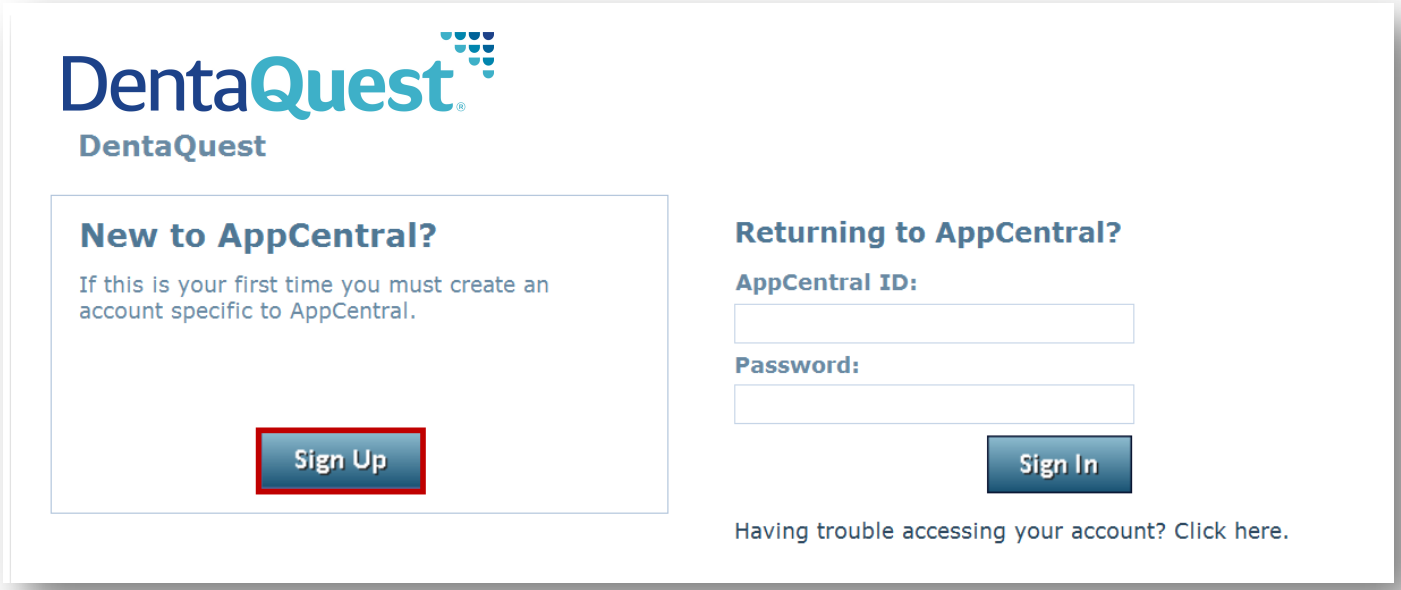
2. Click Submit 

3. Select the products you wish to accept



4. Click 

5. Click, Sign Up



6. Create Account
    a. Enter Provider Name
    b. AppCentral ID (Username)
    c. Password
    d. Personal Email (Providers personal email)
    e. Credentialing Contact Email (the contact person for credentialing related questions)
    f. Security Question
    g. Read and Accept terms of use agreement

Note: An account will need to be created for each individual provider.

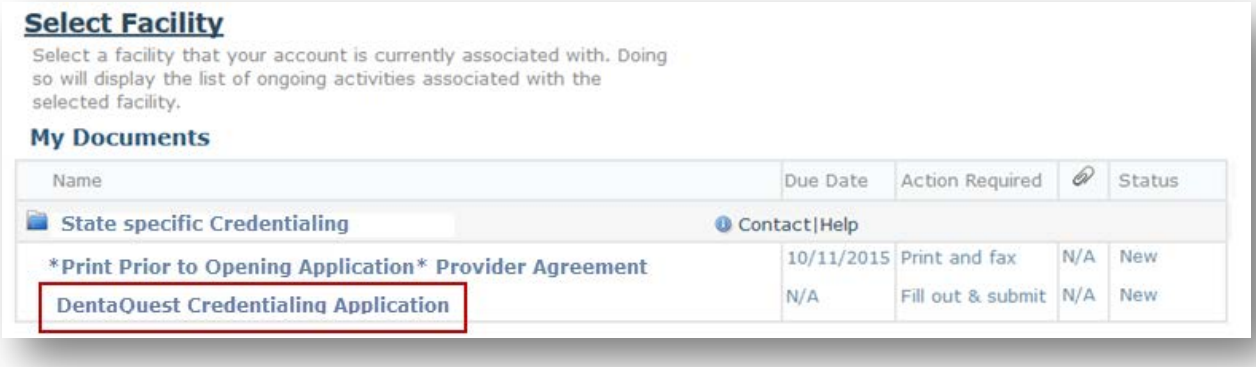
7. Click Create my account 

Completing the Credentialing Application

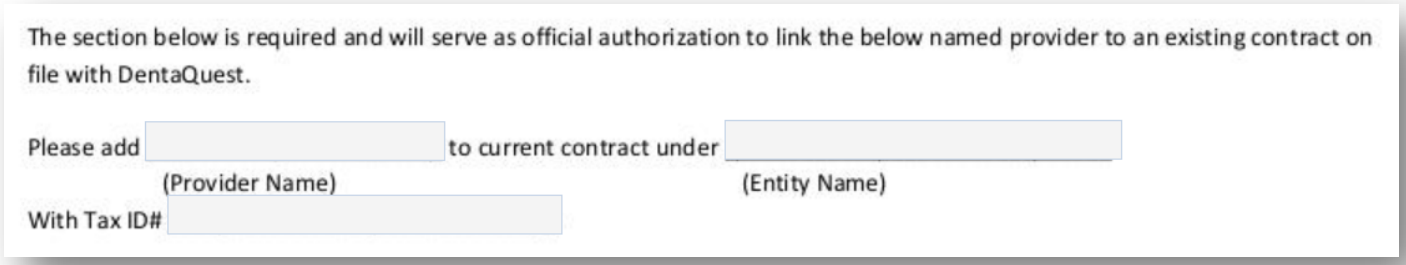
Note: All fields in **RED** are required before the application can be submitted

1. Print **Provider Agreement**
   - This document will need to be completed and returned with the application if the business (billing entity) is new to DentaQuest
     - Directions on how to attach or fax documents are at the end of this instruction manual
   - This document contains
     - Provider Agreement
     - W9
     - EFT (Electronic Funds Transfer) Waiver Form (required to be completed if you do not want payment to be sent via EFT)

2. Select **DentaQuest Credentialing Application**



3. Is the enrolling provider with a
    - New Business with DentaQuest, or
    - An Existing Business with DentaQuest
        - Please Add = Enrolling providers Name
        - Entity Name = Business Name

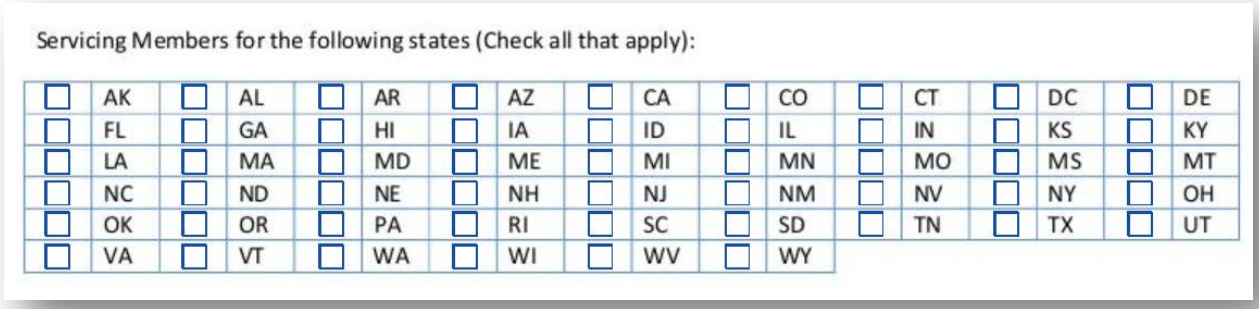

The section below is required and will serve as official authorization to link the below named provider to an existing contract on file with DentaQuest.

Please add _____ to current contract under _____

(Provider Name) (Entity Name)

With Tax ID# _____

4. Select all states that you services members for


Servicing Members for the following states (Check all that apply):

☐	AK	☐	AL	☐	AR	☐	AZ	☐	CA	☐	CO	☐	CT	☐	DC	☐	DE
☐	FL	☐	GA	☐	HI	☐	IA	☐	ID	☐	IL	☐	IN	☐	KS	☐	KY
☐	LA	☐	MA	☐	MD	☐	ME	☐	MI	☐	MN	☐	MO	☐	MS	☐	MT
☐	NC	☐	ND	☐	NE	☐	NH	☐	NJ	☐	NM	☐	NV	☐	NY	☐	OH
☐	OK	☐	OR	☐	PA	☐	RI	☐	SC	☐	SD	☐	TN	☐	TX	☐	UT
☐	VA	☐	VT	☐	WA	☐	WI	☐	WV	☐	WY						

5. Click  to get to the next page

    Note: The Page Backward and Page Forward buttons  are located on the right hand side on the top and the bottom of the page

6. Complete the **General Information** Section
7. Complete the **Other Names** Section, if applicable

    Note: Please be sure to attach documentation of the name change (i.e. – marriage certificate, legal name change documentation, etc.)

8. Complete the **Provider Languages** Section
    - Please select all applicable languages spoken by the provider

    Note: If more than three entries are needed, click on 

to include additional languages

9. Complete the **Licensure** Section
    - Include all current and past licensees

    Note: If more than two entries are needed, click on 

to include additional licenses

10. Complete the **DEA Registration** Section
    - Include all current and past DEA License(s)
    - If you select **Not Applicable** or **In Process**, a DEA Release Form will need to be attached
    - A DEA is required for all states that you service members in. If your DEA License is registered in a state other than the one you are applying for; please attached a DEA Release Form

    Note: If more than one entry is needed, click on 

to include additional licenses

11. Complete the **CDS Registration** Section
    - Include all current and past CDS License(S)

    Note: If more than one entry is needed, click on 

to include additional licenses

12. Complete the **Education** Section

13. Complete the **Specialties & Boards** Section

14. Complete the **Residency/Continuing Education Section**, as applicable
    - Check 

if you did not attend a Residency/Continuing Education Program

    Note: If the American Board Certified Diplomat box is checked on previous page, completion of Residency is required

15. Complete **Hospital & Healthcare Affiliations Section**, as applicable
    - Check 

if you do not have any hospital affiliations

16. Complete the **Professional Liability Insurance** Section
    - A current copy of the insurance certificate will need to be attached prior to submitting the application.

    Note: If insurance will expire within the next 30 days, also include the insurance certificate for the upcoming coverage period

17. Complete the **Office Location(s)** Section
    - For additional location page(s), click 

18. Complete **Billing Address** Section
    - If the billing information is the same as the Primary Office Location, check

19. Complete **Correspondence Address** Section
    - If the correspondence Address is the same as the Primary Office Location, check

20. Complete Credentialing Contact Information
    - If the credentialing contact information is the same as the Correspondence information, click

21. Complete the **Work History** Section
    - The past 10 years of work history is required
    - MM/YYYY format is required
    - If you graduated within the last six months, check

    Note: If more than six entries are needed, a Curriculum Vitae (CV) may be attached

22. Select the applicable choice on the **EFT Form**

- If the business is existing with DentaQuest and already receiving payment via EFT, select

  Business Entity has EFT currently ☐

  TIN: _____

- If the business does not want payment sent via EFT, select

  Business Entity does not want to take EFT at this time ☐

  TIN: _____

  - The EFT Waiver Form will be required to be attached prior to submitting the application

- If the business would like to receive payment via EFT, select

  Business Entity would like to add New EFT ☐

  TIN: _____

  - Complete the remainder of the form
  - A copy of a voided check will need to be attached prior to submitting the application

23. Complete the **Questionnaire**

Note:

- DentaQuest uses the National Practitioner Data Bank (NPDB) top verify and adverse licensure, malpractice history, hospital privileges and professional society actions against physicians and dentists related to quality of care. To obtain a copy of your NPDB report, **please perform a Self-Query** by visiting https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp
- If you Answer "Yes" to questions 1-13 and 15-16, the following information is required in your response:

  Please enter the following information in the Explanation Section below:

  - In your own words, a description of the adverse action
  - Date of adverse action
  - Outcome of the adverse action

Note: A copy of your Self-Query is not acceptable unless you have completed the 'Subject Statements' Section

24. Complete the **Certification, Statements and Signature**

Note: The date must be current date.

25. Complete the **Disclosure of Ownership**

NOTE: All sections need to be completed before the document can be considered complete. This includes all sections of the document and all questions. If a correction is made to the document, the error needs to be lined out and dated and initialed.

Section 1:

- This section needs to be completed in its entirety. Information populated in section 1 should match the information on the W9 form.
- If provider states that TIN was completed within the last 6 months, this is the only section that needs to be filled out.

Note: Note: The version that must be on file with DQ is this same version that is in the application

This document MUST be completed and signed by an Owner of the Business Entity. If there are multiple Service Offices associated with this Business Entity, please attach a complete list of ALL Service Offices including their address.

The Disclosure of Ownership is a CMS (Center for Medicare/Medicaid Services) and Client Required document for DentaQuest to obtain during the contracting/credentialing process. If this documentation is not received, the credentialing process will be delayed.

Current copy of the Disclosure of Ownership for Business Entity already on file with DentaQuest - **COMPLETED WITHIN THE LAST 6 MONTHS.**

TIN: _____ ☐ Yes ☐ No

Disclosure of Ownership and Control Interest Statement

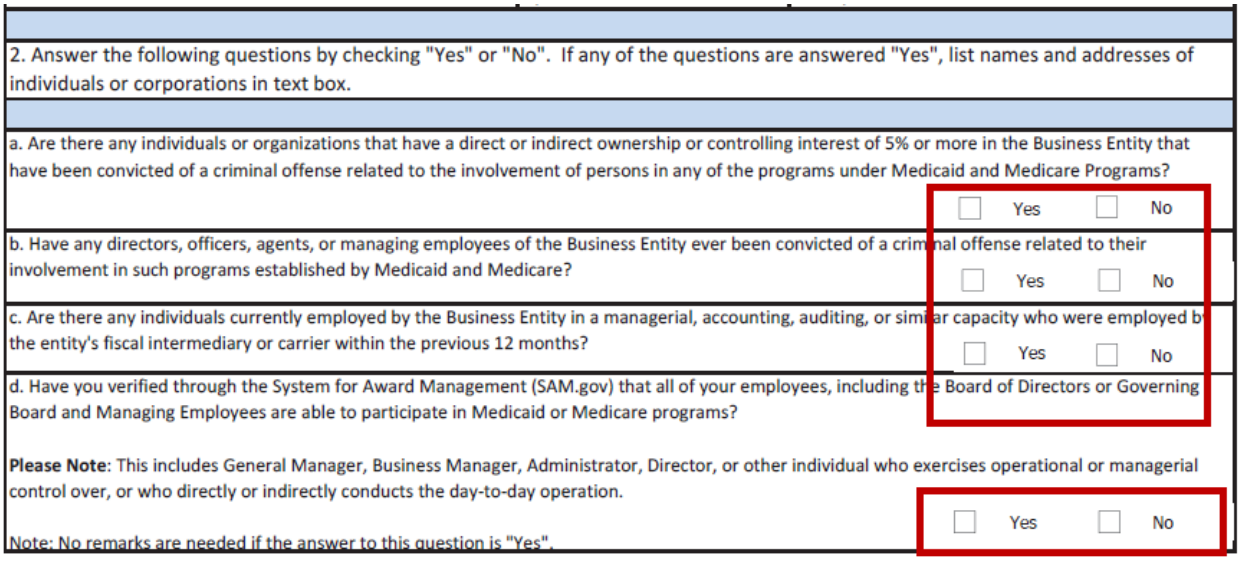
Completion and submission of this form is a condition of participation in any program established by Medicaid or Medicare only. One full and accurate disclosure of ownership is required for each Business Entity. Failure to submit the requested information will result in refusal to participate in the DentaQuest Network or in termination of an existing agreement. If there are any changes in the ownership an updated form must be submitted.

1. Identifying Information

Name of Entity	DBA	Tax ID	Telephone Number
Street Address		City	
State	Zip	County	

Section 2:

- Questions 2a -2c require a response.
  - If any questions 2a – 2c has a "YES" response, an explanation is required in the provided "Remarks" area of page 4.
- Question 2d requires a response.
  - If the question has a "NO" response, an explanation is required in the provided "Remarks" area of page 4. **PLEASE NOTE: It is a requirement of DentaQuest for business' to perform this search.**



2. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in text box.
a. Are there any individuals or organizations that have a direct or indirect ownership or controlling interest of 5% or more in the Business Entity that have been convicted of a criminal offense related to the involvement of persons in any of the programs under Medicaid and Medicare Programs? ☐ Yes ☐ No
b. Have any directors, officers, agents, or managing employees of the Business Entity ever been convicted of a criminal offense related to their involvement in such programs established by Medicaid and Medicare? ☐ Yes ☐ No
c. Are there any individuals currently employed by the Business Entity in a managerial, accounting, auditing, or similar capacity who were employed by the entity's fiscal intermediary or carrier within the previous 12 months? ☐ Yes ☐ No
d. Have you verified through the System for Award Management (SAM.gov) that all of your employees, including the Board of Directors or Governing Board and Managing Employees are able to participate in Medicaid or Medicare programs? **Please Note**: This includes General Manager, Business Manager, Administrator, Director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation. Note: No remarks are needed if the answer to this question is "Yes". ☐ Yes ☐ No

Section 3:

- Section 3a This should include all the owners of the organization (List each member of the Board of Directors or Governing Board and Managing Employees also including General Manager, Business Manager, Administrator, Director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation.). If needed, a list of owners can be attached and "See Attached" can be written in this section.

- Section 3b needs to be completed. Information populated in this section should match the information on the W9 form.
  - Section 3c If the business is a corporation, this section needs to be completed.

3a. List names, addresses, and EIN for individuals or organizations having direct or indirect ownership or a controlling interest in this Business Entity. (List each member of the Board of Directors or Governing Board and Managing Employees also including General Manager, Business Manager, Administrator, Director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation.) List any additional names and addresses under "Remarks" on page 4. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name of Individual or Entity	DOB	Address		SSN (if listing an individual) TIN (if listing an entity)
		Address	Zip	
		City	State	
		Address	Zip	
		City	State	
		Address	Zip	
		City	State	

b. W9 Type

☐ Sole Proprietorship ☐ Partnership ☐ Corporation
☐ Unincorporated Associations ☐ Other

c. If this Business Entity is a corporation, list names, addresses of the Directors, and EINs for entities.

- Section 3d If this is answered “YES”, names and addresses of owners of the business who also own other Medicaid and Medicare organizations.

Disclosure of Ownership and Control Interest Statement			
Check appropriate box for each of the following questions: d. Are any owners of the Business Entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.			☐ Yes ☐ No
Name	**Address**		**EIN**
	Address / Zip		
	City	State	
	Address / Zip		
	City	State	
	Address / Zip		
	City	State	

Sections 4-5:

- Requires a date populated in the space provided, if any are answered with a “YES” response.

4a. Has there been a change in ownership or control within the last year? If yes, give date _____	☐ Yes ☐ No
b. Do you anticipate any change of ownership or control within the year? If yes, when? _____	☐ Yes ☐ No
c. Do you anticipate filing for bankruptcy within the year? If yes, when? _____	☐ Yes ☐ No
5. Is this entity operated by a management company, or leased in whole or part by another organization? If yes, give date of change in operations _____	☐ Yes ☐ No

Section 6:

- Can be answered with a “YES” response without an explanation.

6. Has there been a change in management (such as: change in Director, a new Administrator, contracting operations of facility to a management corporation, hiring or dismissing employees with 5% or more interest, or similar change) within the last year?	☐ Yes ☐ No

Section 7:

- If section 7a is answered with a "YES" response, and the business entity is part of a chain, a list of the affiliated locations that includes the name address and EIN # of every location is required.

7a. Is this entity chain affiliated? (If yes, list name, address of Corporation, and EIN)	☐ Yes ☐ No	
Name	EIN	
Address		
City	State	Zip

- If section 7b is answered with a "YES" response, a list of the locations that the location was affiliated with in the past is required.

7b. If the answer to Question 7a. is No, was the entity ever affiliated with a chain? (If yes, list Name, Address of Corporation, and EIN)	☐ Yes ☐ No	
Address		
City	State	Zip

Signature Section:

- All fields must be populated. This form must be signed by an owner of the business.

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Owner (Typed)	Title
Owner Electronic Signature	Date

26. Complete the **DentaQuest Application Checklist**

Note: This section is used as a checklist to ensure all required documentation is attached.

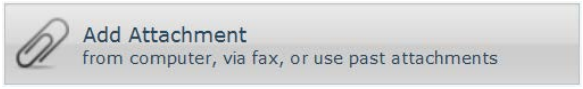
Attaching Documents

There are two ways to attach documents

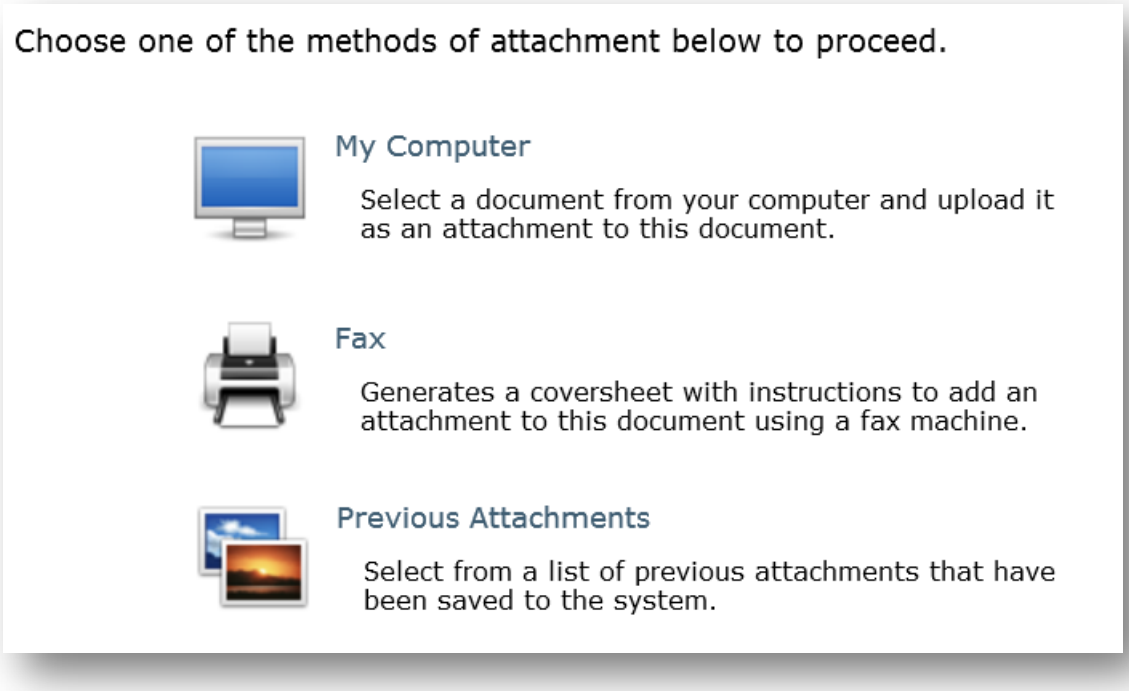
Helpful Hint: Gather all required documentation prior to this step

- If you select **My Computer**, have all documents scanned and saved in an easily assessable on your computer
- If you have trouble with attaching documents, please check your pop-up blocker and/or your firewall settings.

1. Click on 

located on the top of the page
2. Select 

3. Select Attachment Method

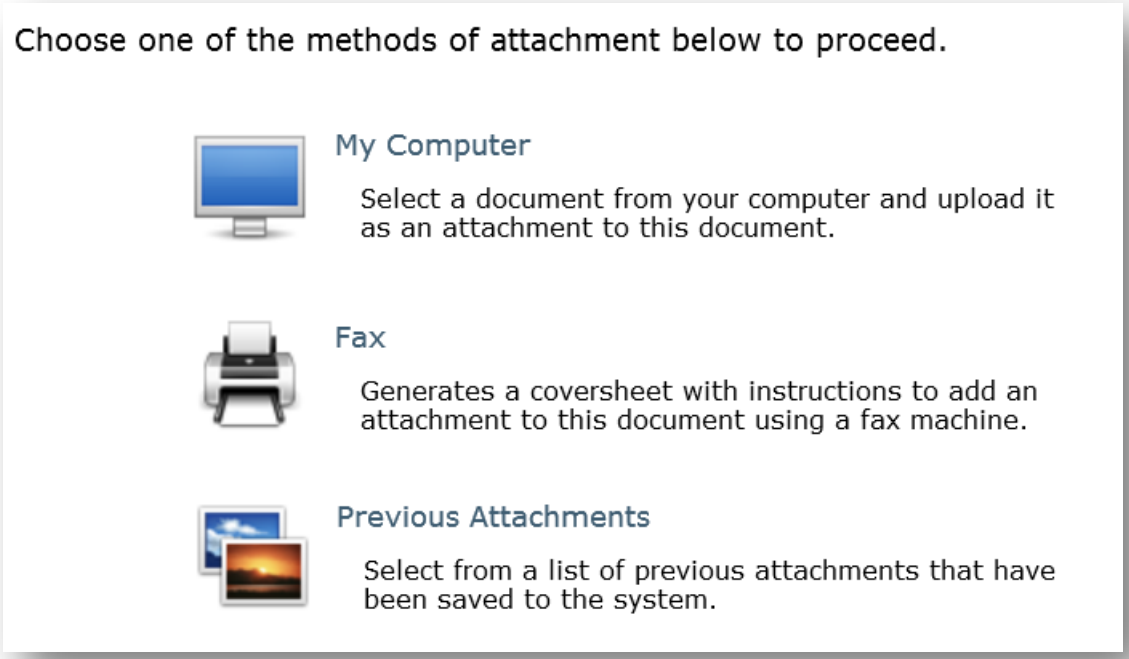


Or

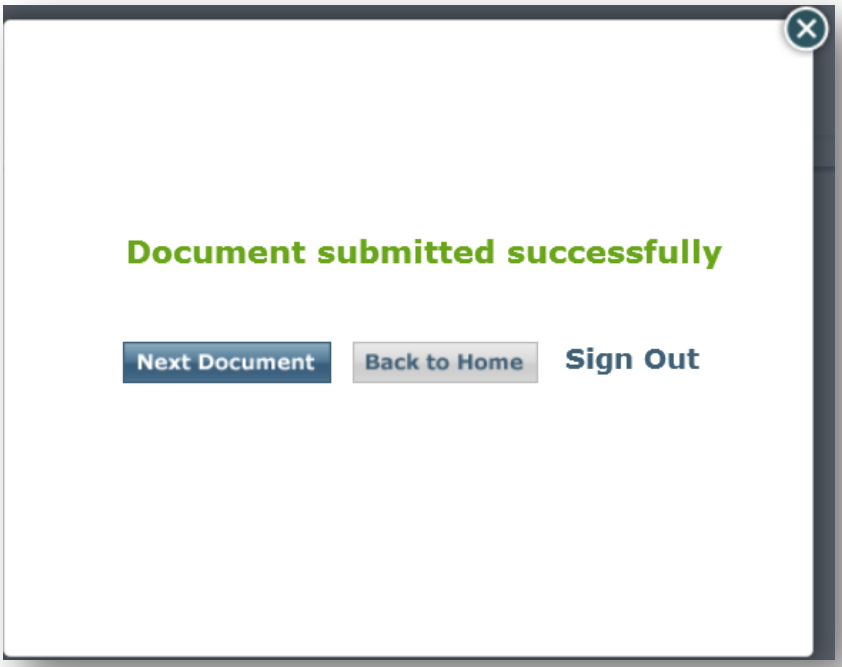
1. Click on 

2. Select 

3. Select Attachment Method



When the application has been completed and all required documents are attached, click


Document submitted successfully
Next Document
Back to Home
Sign Out