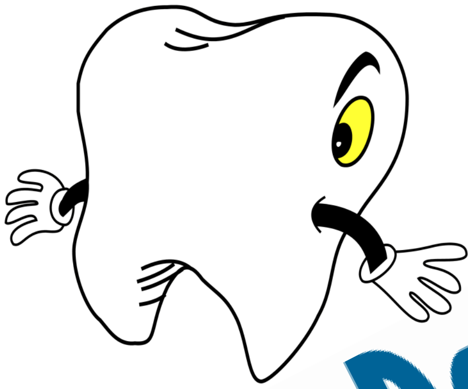


Savon Dental Plan®

America's Dental Plan

Fast Track Network Preferred Provider And Center Add-on Forms

Covers All Zones

For Credentialed Centers Add-on

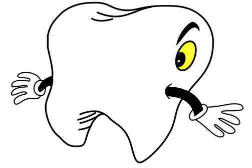
(602)841-3494 • 1-800-809-3494 • Fax (602) 589-0417

Corporate Office: Phoenix, Arizona

Mailing Address: PO Box 54277, Phoenix, AZ 85078

Website: www.SavonDentalPlan.com

Email: ProviderServices@SavonDentalPlan.com



Savon Dental Plan

Credentialing Check List

Please make sure that you are submitting all of the following items.

For each dental center please submit:

[ ] 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 pages are permissible

For each provider please submit:

[ ] The COMPLETED one (1) page PROVIDER PROFILE

We only require numbers and expiration dates of the following items, we do not require copies of them.

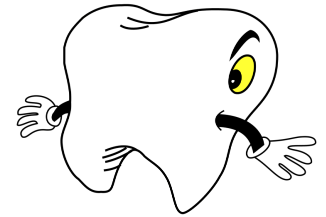
[ ] PROFESSIONAL LIABILITY INSURANCE POLICY NUMBER AND EXPIRATION DATE

[ ] 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).

Adress:____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 hygienists 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)

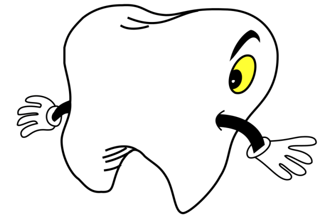
Please Tell Us About Options and Special Equipment that you have

(please check all that apply to your office)

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

[ ] Other (please explain):____

Center Profile



Page II

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)____

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

[ ] Personal Checks [ ] 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

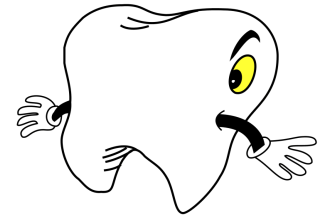
Compliance Procedures

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

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? ____

Address:_______________________________________City:____________________________State:____________Zip:___________

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 participation 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	Pedodontics	0 1 2 3 4 5 6 7 8 9 10
Endodontics	0 1 2 3 4 5 6 7 8 9 10	Prosthodontics	0 1 2 3 4 5 6 7 8 9 10
Oral Surgery	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
Periodontics	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: (for Savon Dental Plan's use in case of extreme emergency)

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.**