Privacy Protected

Name: ____ License State:________________

Practice Name: ____ License #:____________________

Street: ______________________________ City: ______________ State: _________ Zip:______ County:_____________

Provider SSN #: ____ Date of Birth: ________/________/________

Provider Phone #: (   ) - ________-__________ Provider Fax #: (   ) - ________-__________ Email:________________________

Medicaid #:______________________________ Medicare #:____________________________ NPI #:__________________________

TIN # you will use to submit to Rayant:____

(please include a copy of your W9 form that corresponds with the above TIN #)

PLEASE MARK YES OR NO AND INCLUDE A COPY OF THE DOCUMENT FOR EACH YES

- ☐ **No** ☐ **Yes** **Current State License (include copy)**
- ☐ **No** ☐ **Yes** **DEA (include copy) (DEA must match the License State)**
- ☐ **No** ☐ **Yes** **Current Professional Liability/Malpractice Insurance Declaration Page (include copy)**
- ☐ **No** ☐ **Yes** **Change In Practice In Last 5 Years. If Yes, Please Supply a 5 Year Work History Including Dates and Addresses (Curriculum Vitae / Resume is acceptable)**
- ☐ **No** ☐ **Yes** **State Drug Certificate (include copy)**

Dental School (include copy): ____ Year Completed: ________ State: _______

Street: ____ City: ______________________

☐ **Check** if **GENERAL** Dentist, otherwise list additional Specialty information below or on a separate sheet of paper, if applicable.

Primary Specialty:____

Primary Specialty School / Training (include copy):____________________________ Year Completed: _________ State: _________

Street:____ City:________________________________

Secondary Specialty: ____

Secondary Specialty School / Training (include copy): ____________________________ Year Completed: _________ State: _________

Street:____ City:________________________________

CHECK ALL THAT APPLY

- ☐ **No** ☐ **Yes** **Specialty Certified By an American Board (excluding State Board)** ☐ **Primary** ☐ **Secondary**
- ☐ **No** ☐ **Yes** **Hospital Privileges:**

ACTIVE Hospital Name (Primary Admitting Facility): ____

City: ________________________________

- ☐ **No** ☐ **Yes** **Practiced With Any Other Licenses In The Past 5 Years. (List State & License Number)**

____

I authorize Rayant - Dental Programs and CreDENTALs to collect any information necessary to verify the information on this application.

Dentist's Signature: ____ Date: ________/________/________

Mail To: VerifPoint P.O. Box 3959, Huntington Beach, CA 92605-3959 Phone: 949-770-5290 Fax: 949-470-0838

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