

### Connection Dental Attestation Form – Oklahoma Only

FOR EACH “YES” RESPONSE, PLEASE INCLUDE A DETAILED EXPLANATION WITH THIS FORM.  
IF QUESTION IS “NOT APPLICABLE,” PLEASE MARK “NO” FOR EACH RESPONSE.

|                                                                                                                                                                                                                                                                                                                                                            |     |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Has your license(s) to practice in any jurisdiction(s), whether completed or still pending, been lost, denied, limited, suspended, revoked, not renewed; or have you been placed under probation, subjected to disciplinary action, or have you voluntarily relinquished any item in anticipation of these actions?                                     | Yes | No |
| 2. Has your professional liability insurance ever been denied, suspended, revoked, canceled, or not renewed?                                                                                                                                                                                                                                               | Yes | No |
| 3. Has your state or federal DEA or any State Drug Certificate Registration ever been lost, denied, suspended, canceled, or subjected to any disciplinary action?                                                                                                                                                                                          | Yes | No |
| 4. Has your status as a provider, or membership with any professional organization, ever been lost, denied, suspended, disciplined, canceled, or sanctioned; or are you currently under investigation by any municipal, state, federal or any other governmental agency, or any HMO, PPO or other prepaid health plan (e.g. Medicare, Medi-Cal, Medicaid)? | Yes | No |
| 5. Are your privileges or memberships at any hospital or institution (Military service) currently under investigation or have they ever been lost, denied, suspended, reduced, disciplined, or not renewed?                                                                                                                                                | Yes | No |
| 6. Have you ever been prevented from performing any procedures within the scope of privileges and duties as a dental care provider?                                                                                                                                                                                                                        | Yes | No |
| 7. Do you currently, or have you ever engaged in the unlawful use of drugs, including the improper use of prescription drugs?                                                                                                                                                                                                                              | Yes | No |
| 8. Do you have any felony or misdemeanor charges pending against you other than a traffic violation, or have you ever been convicted or pleaded guilty or “nolo contendere” to a felony or a misdemeanor?                                                                                                                                                  | Yes | No |
| 9. Have you ever been involved, or are you currently involved in ANY claims/ lawsuits, settlements, or judgments (other than divorce or custody)?                                                                                                                                                                                                          | Yes | No |
| 10. Are you currently practicing WITHOUT, or with EXPIRED, Professional Liability/Malpractice Insurance?                                                                                                                                                                                                                                                   | Yes | No |
| 11. Do you have any condition that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of members?                                                                                                                           | Yes | No |

Practitioner hereby certifies that the information provided on this Credentialing Attestation is true and complete and correct to the best of his or her knowledge. Practitioner hereby authorizes GEHA and its authorized representatives to contact individuals and organizations to obtain information pertaining to his or her qualifications for the credentialing and any subsequent recredentialing processes. Practitioner agrees that GEHA, its subsidiaries, employees or representatives, and individuals or organizations providing information to GEHA shall not be liable for any act or omission related to the verification of the information provided in the Credentialing Application, Attestation, or Recredentialing Application process. GEHA will treat information in the Credentialing Application, Attestation and Recredentialing Application that is not publicly available as confidential, unless disclosure is required by law, regulation, or an accrediting organization. Practitioner agrees to advise GEHA of any changes in the information provided on the Credentialing Application, Attestation or Recredentialing Application. Practitioner understands that submission of the Credentialing Application, Attestation, or Recredentialing Application does not guarantee participation or continued participation in the Connection Dental Network. A photocopy of this page shall be considered a valid authorization.

Further, Practitioner acknowledges that as part of the application process, he/she states that they (1) have reviewed Fraud, Waste, and Abuse training within the past 12 months and will review the GEHA Code of Ethical Business Conduct within 90 days of the Effective Date of the GEHA Participating Provider Agreement or (2) have read the (a) overview of the GEHA Compliance Program (b) GEHA Code of Ethical Business Conduct and (c) information on fraud, waste, and abuse, which includes my obligation to report compliance/ethics and fraud, waste and abuse concerns to GEHA. Items A, B, and C, as referenced above, can be found under the Resources Tab, [www.connectiondental.com](http://www.connectiondental.com).

If my application is approved and I enter into an Individual Participating Provider Agreement with GEHA, I understand and agree to annually review the items referenced above as (a), (b), and (c) above and abide by the following compliance obligations:

- 1) That employees will review the materials referenced above and will be advised to report any compliance/ethics and fraud, waste and abuse concerns.
- 2) That any downstream entities with whom I contract for services relative to my dental practice will also be provided the materials referenced above.
- 3) That employees have been screened against both the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and exclusion records accessed through the System for Award Management (SAM), the system that consolidated the capabilities of CCR/FedReg, ORCA and EPLS, formally known as GSA, prior to hire or contract and monthly thereafter. Excluded individuals will be removed from providing services to Medicare Advantage plan members immediately and reported to GEHA.

Practitioner signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner name: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Additional contact name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Return to requestor:**

Connection Dental Network, P.O. Box 6707, Lee's Summit, MO 64064-6707, Fax: 816.257.4439, Phone: 800.505.8880