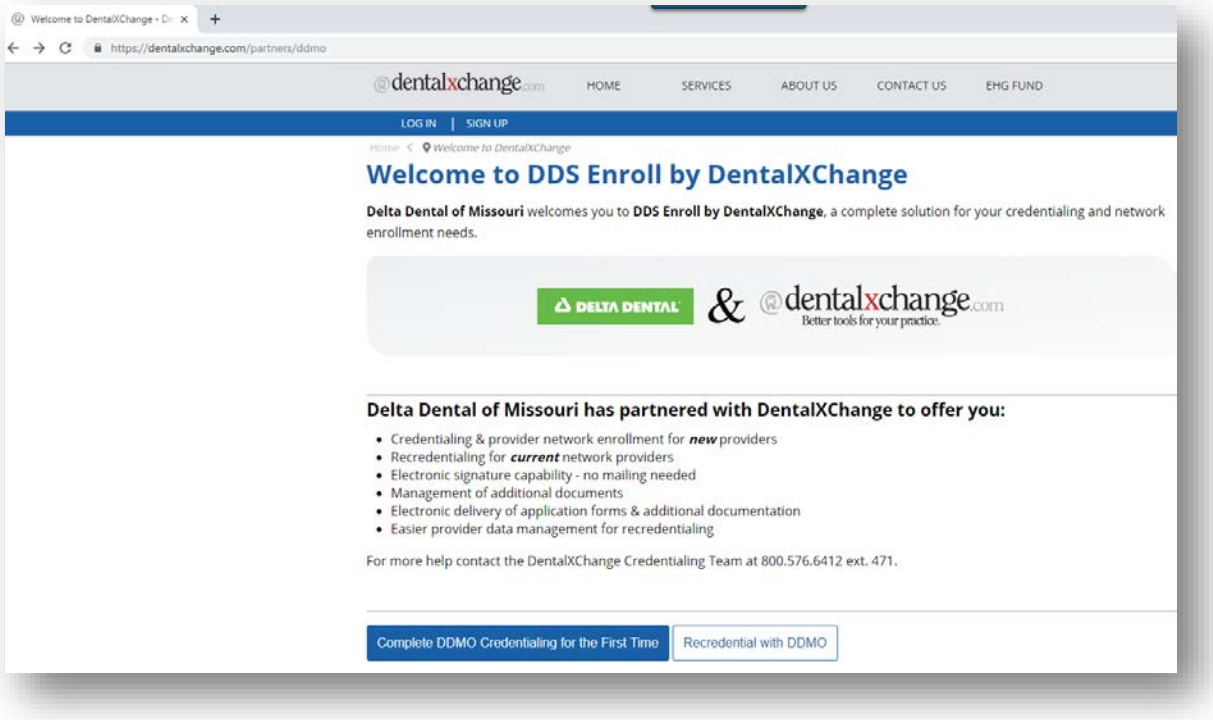
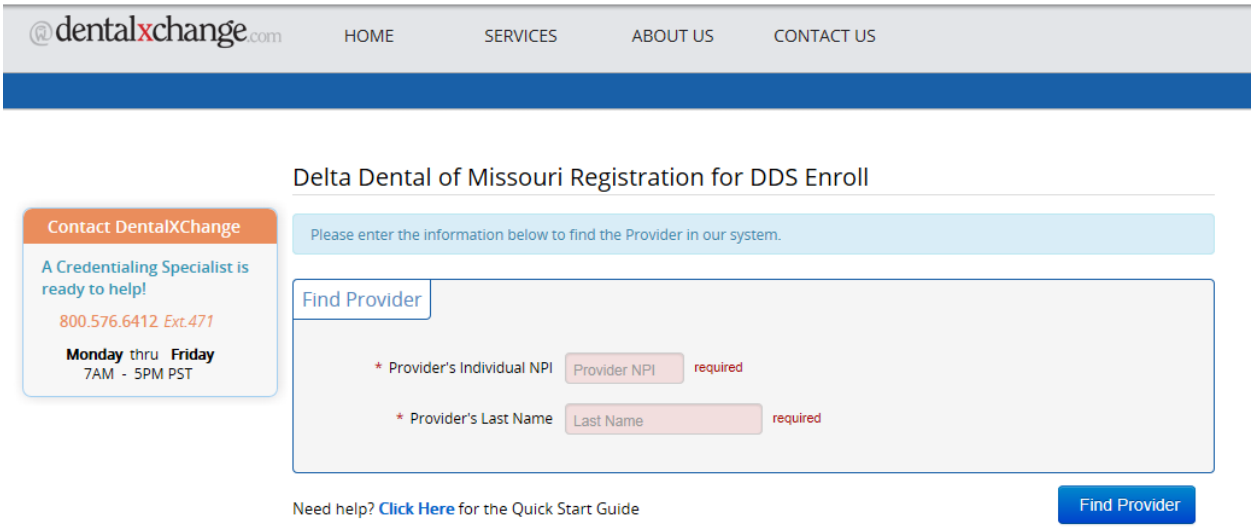
1. Access landing page at www.dentalxchange.com/partners/ddmo for Delta Dental of Missouri Providers or www.dentalxchange.com/partners/ddsc for Delta Delta of South Carolina Providers. The links are also available on Delta Dental's website to be directed to Dental Xchange.
2. Once you are at the landing page, select **Complete Credentialing for the first time** for Initial Credentialing or **Recredential with DDMO/DDSC.**



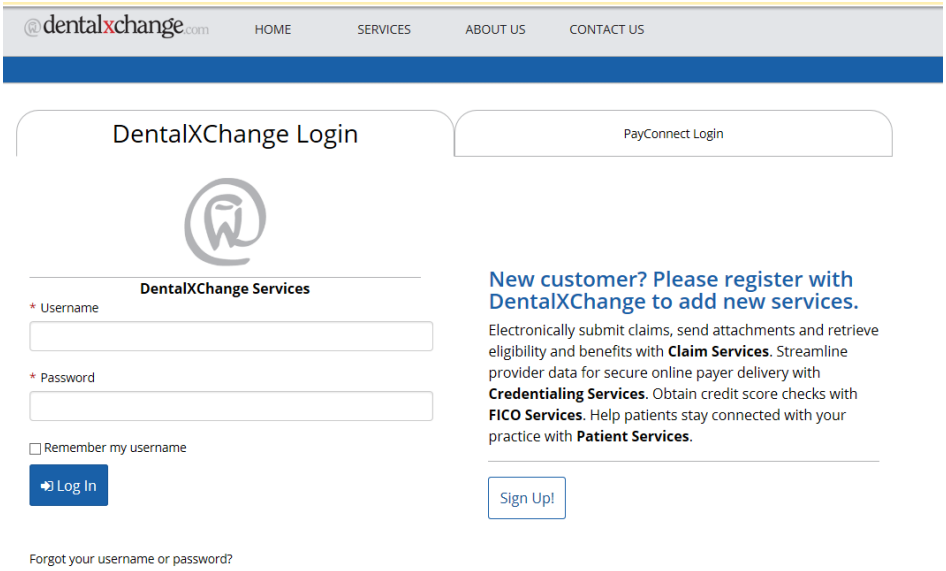
3. You will be required to verify provider information with **NPI Type 1** and **Provider's Last Name.**



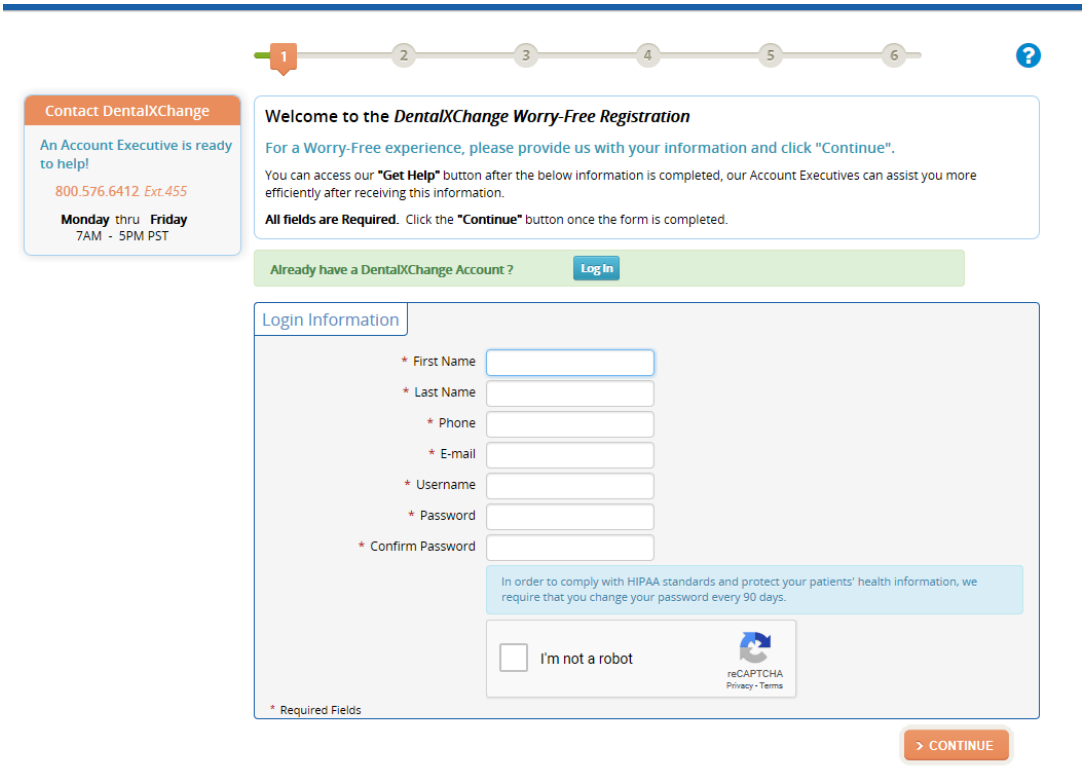
4. Once Provider information is verified, you will come to the below screen.

   New Providers – Click on sign up.

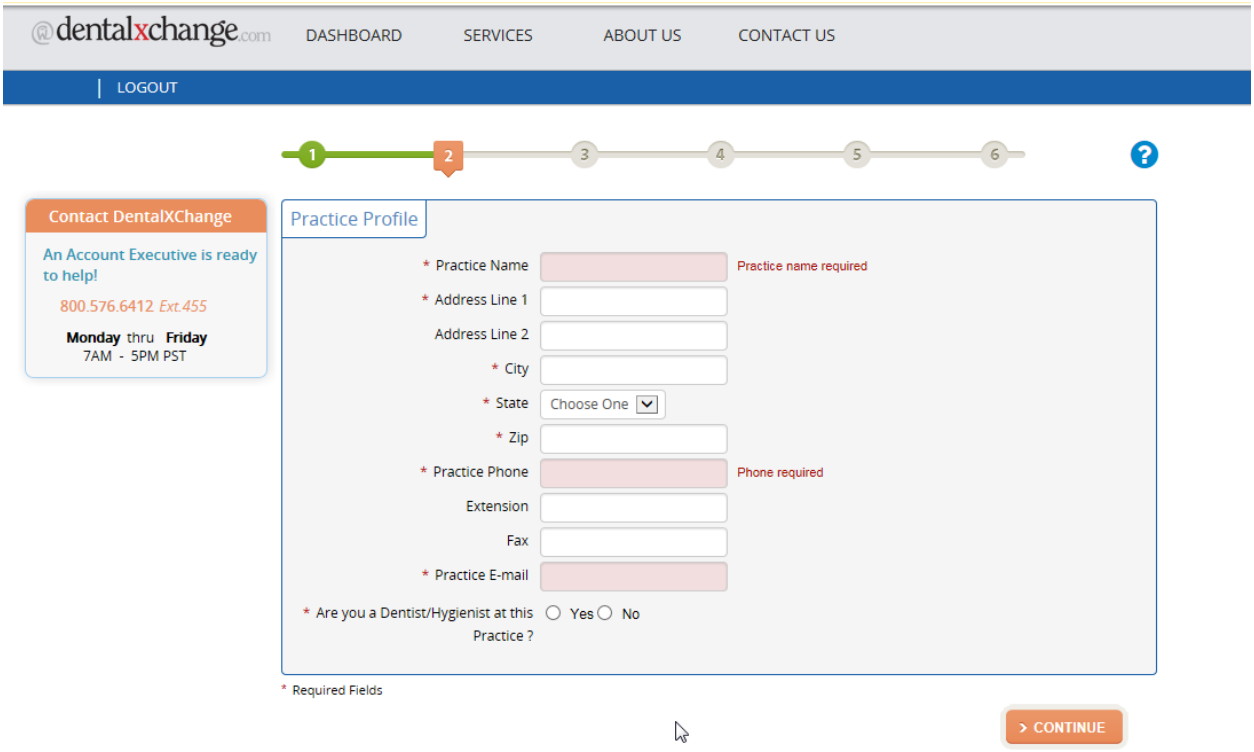
   Existing providers – Can login with username and password



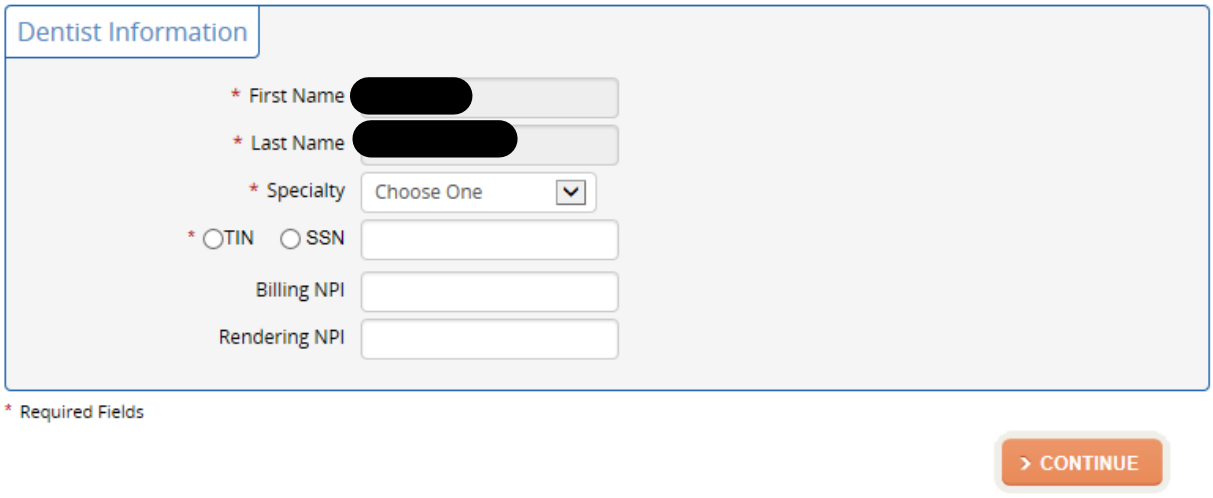
5. **New Providers** are required to complete registration and enter login information below.



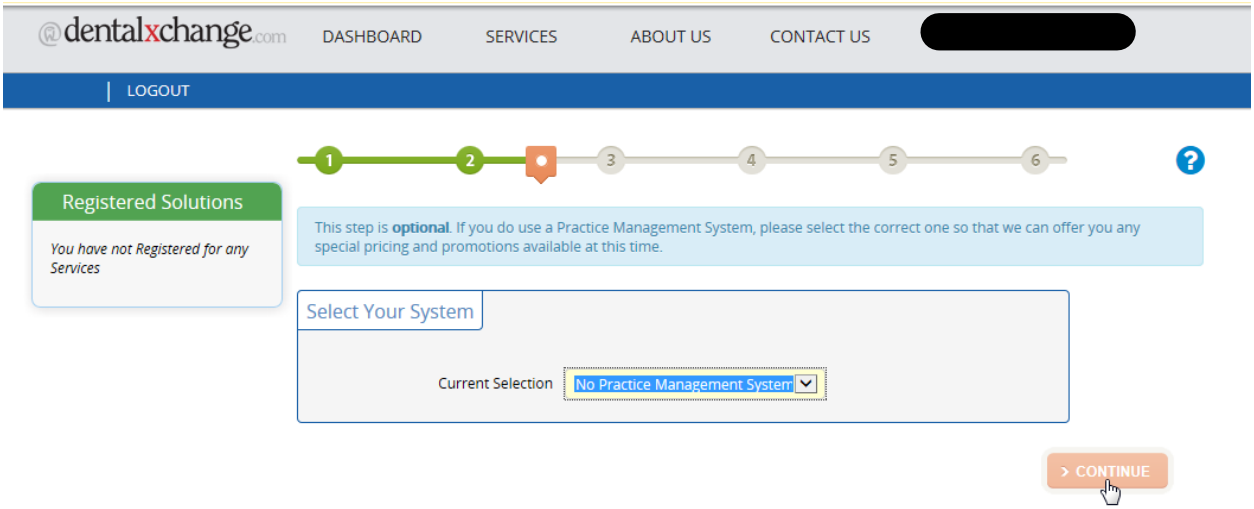
6. **New Provider** enters <u>Practice Information</u>:



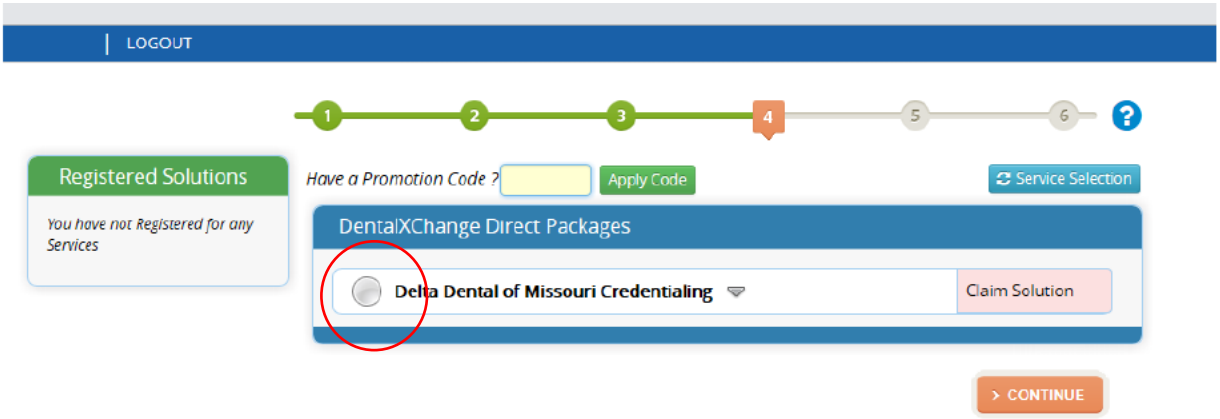
7. **New Provider** will enter information regarding them self.



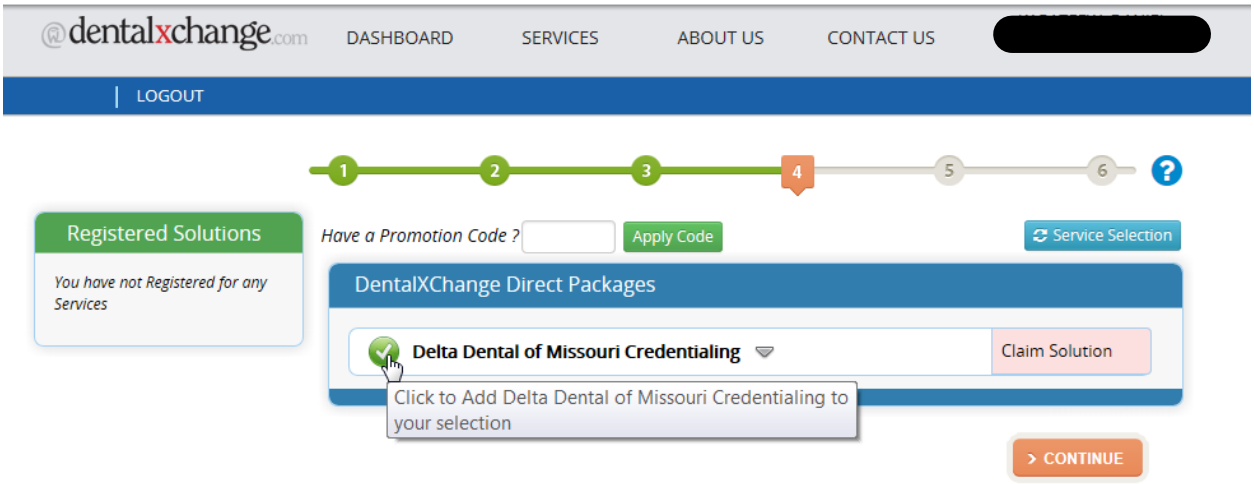
8. Leave the Current Selection as No Practice Management System and click **Continue**.



9. You will click the Bubble to choose Delta Dental of Missouri Credentialing

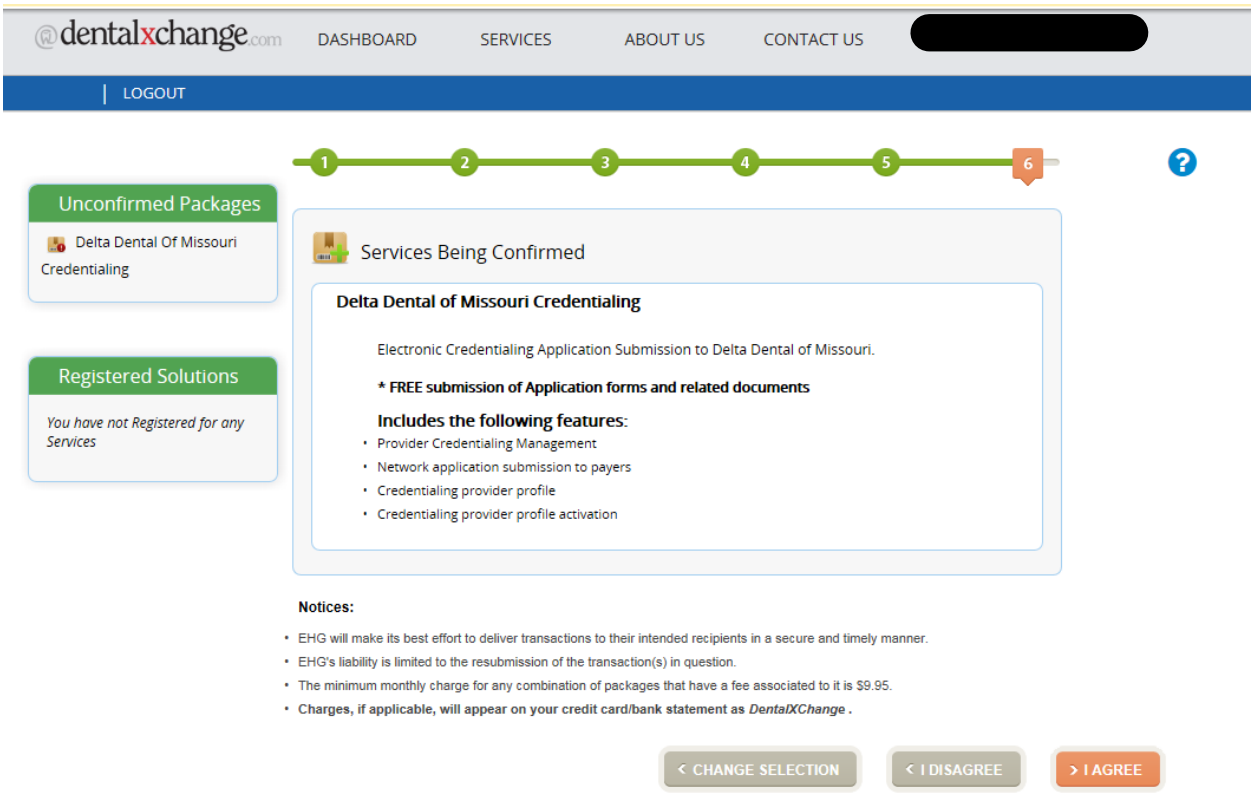


10. After the bubble has a green check mark in it, you will click **Continue** at the bottom.



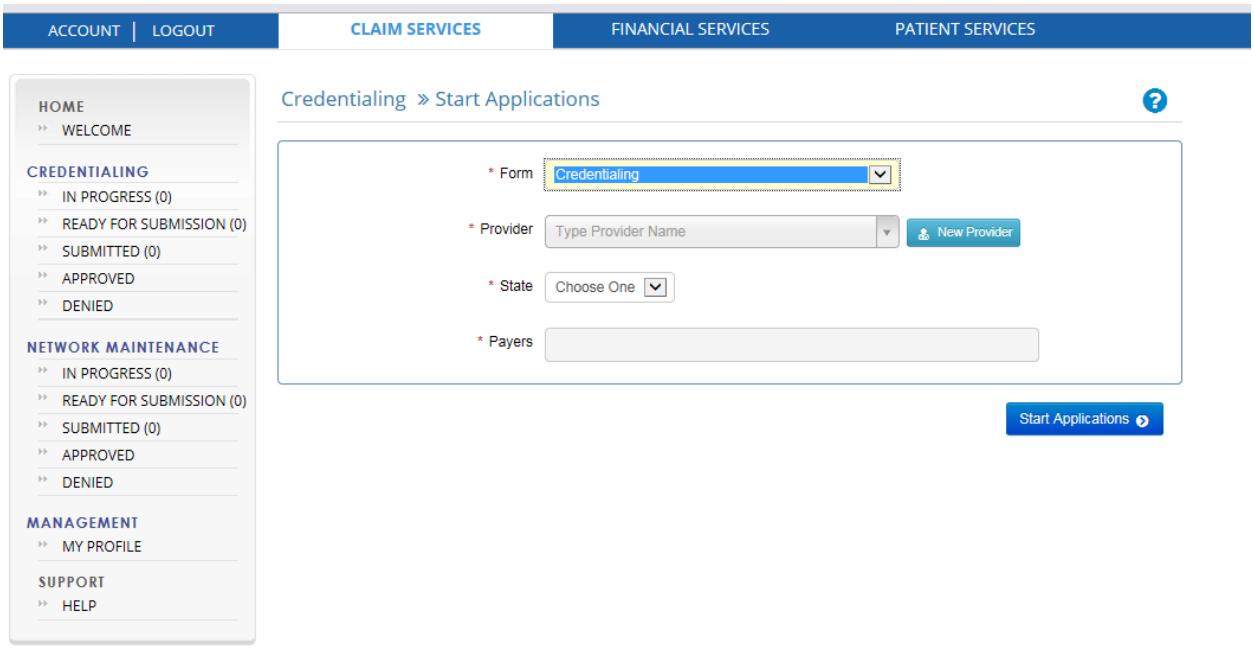
11. **New Provider** agrees to the package:

    Note: This is a Free service, there will be no charges.



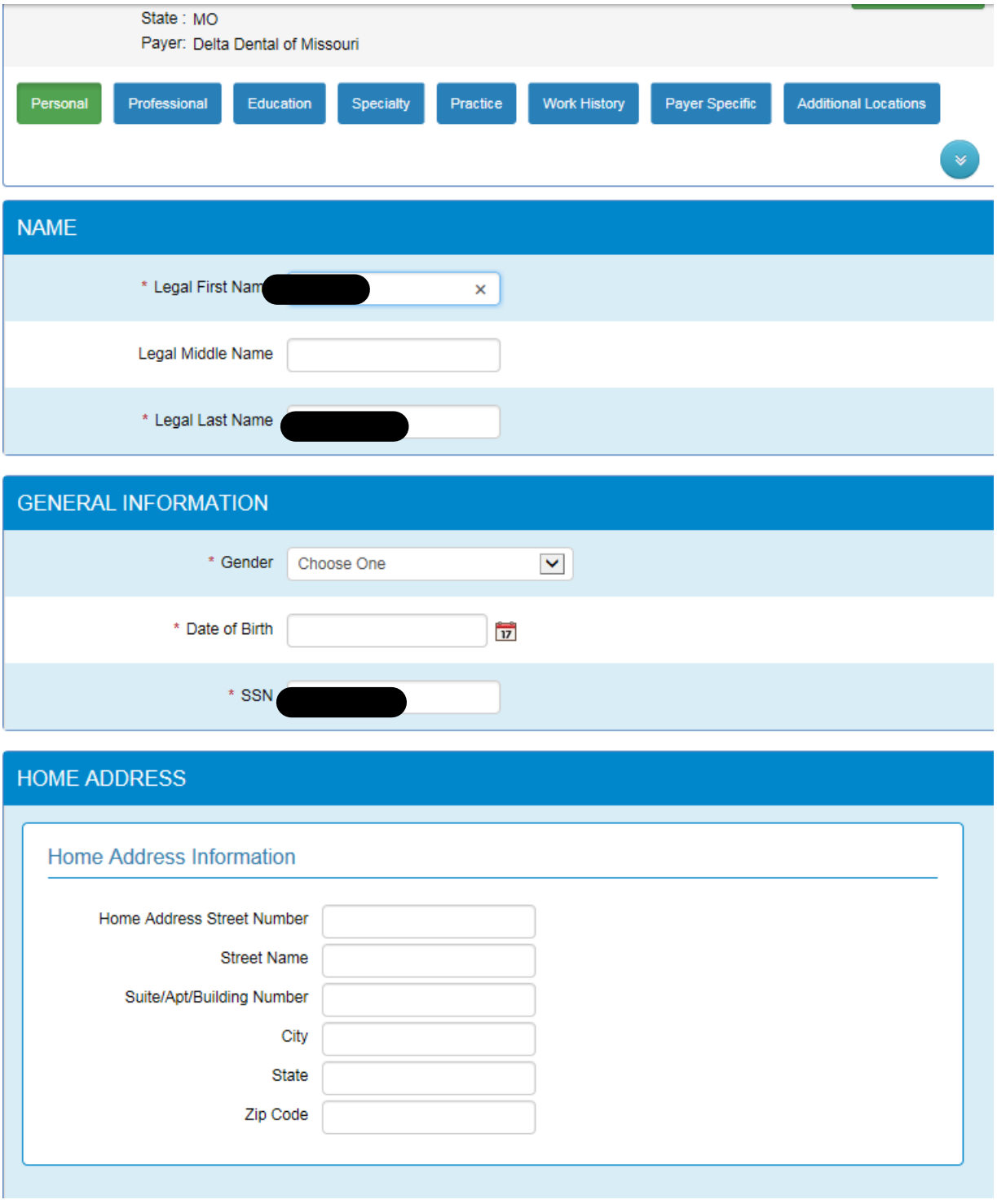
12. **Initial Credentialing providers** will come to the below screen and are required to select:

    Form Type: Credentialing, **Provider**: they will choose themselves from the dropdown, **State**: MO/SC, **Payer**: select Delta Dental of MO/SC. Once all is selected, click on start application.

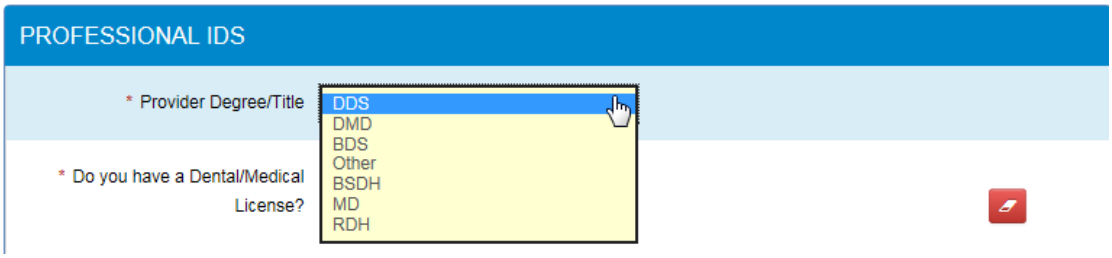


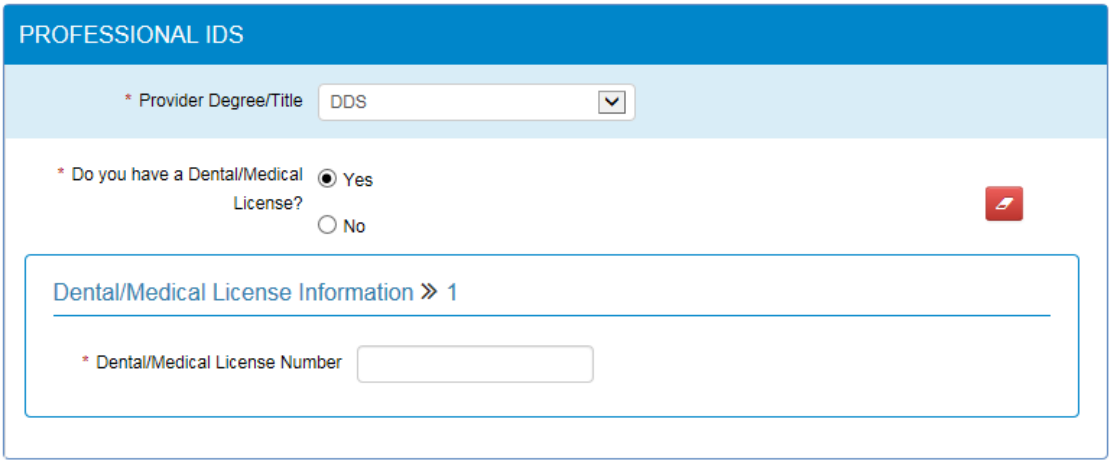
13. When the application is started, providers will come up to the question wizard and are required to answer questions marked with a red (*) asterisk, then select save and continue to move to the next category

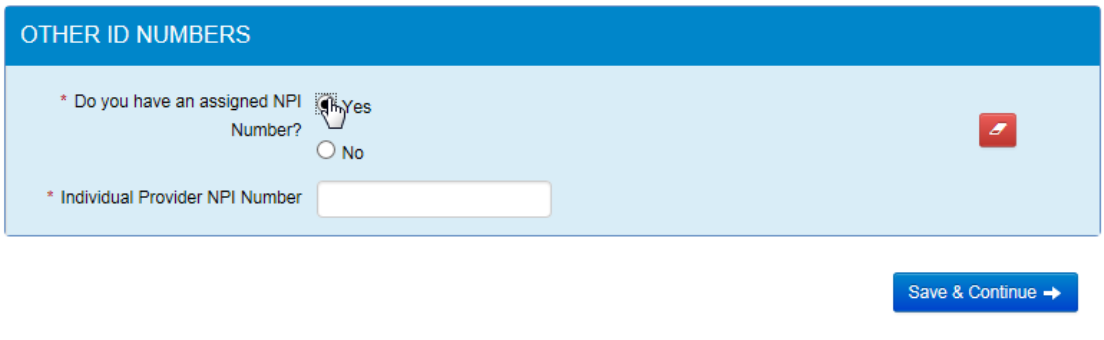
Please note: Re-Credentialing providers are automatically brought to this screen. They do not need to create the application.



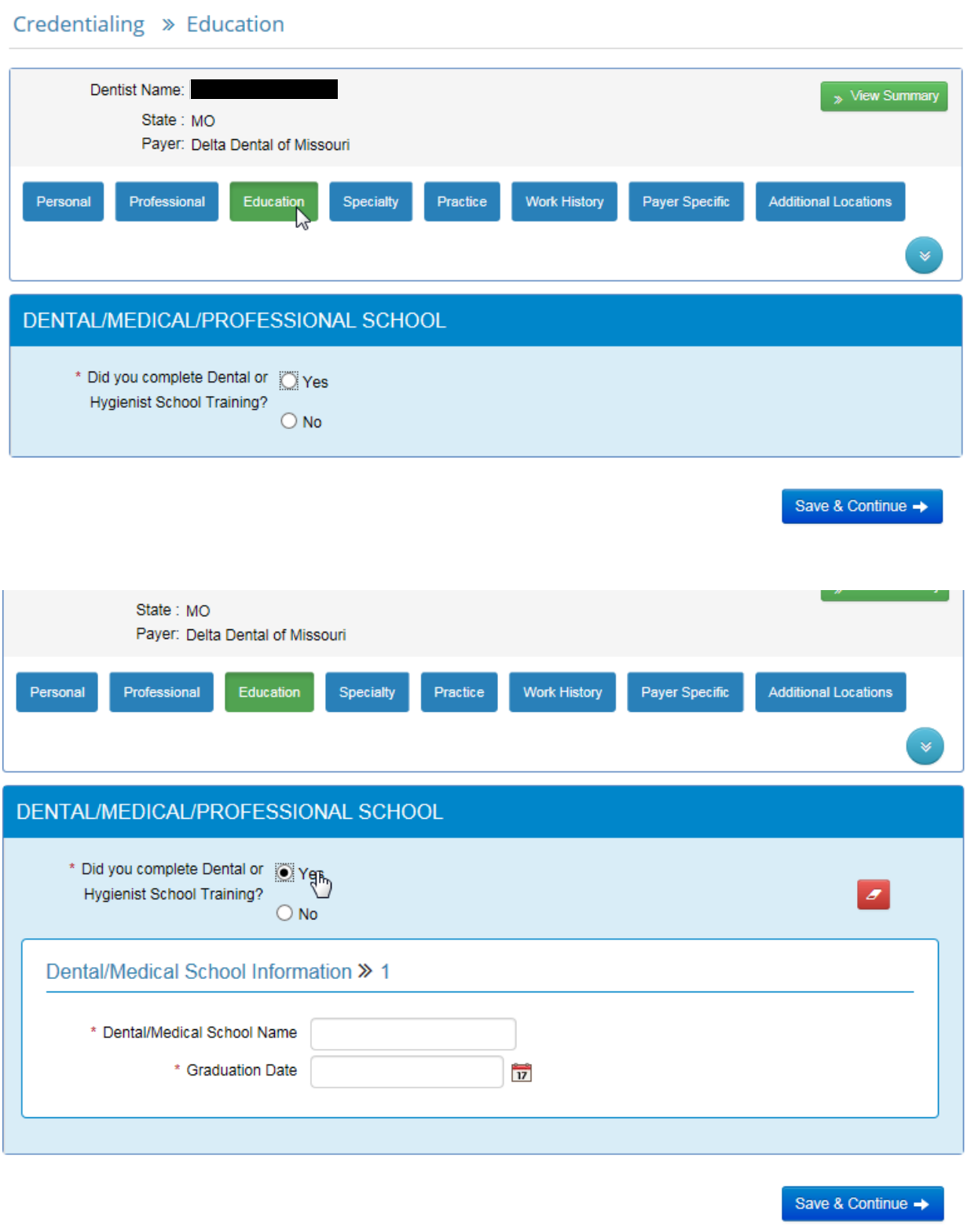
14. The **Professional** section of the question wizard.



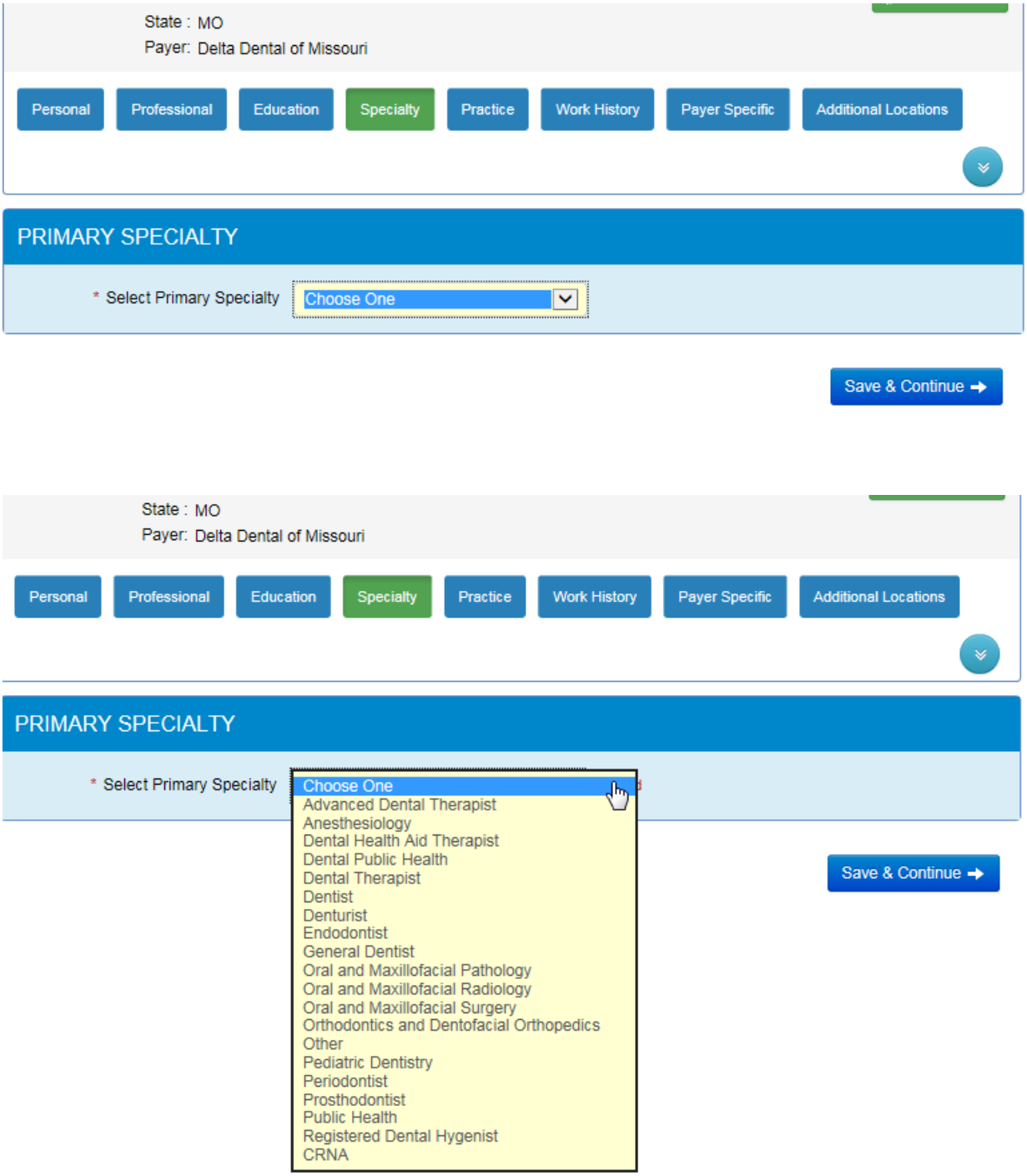




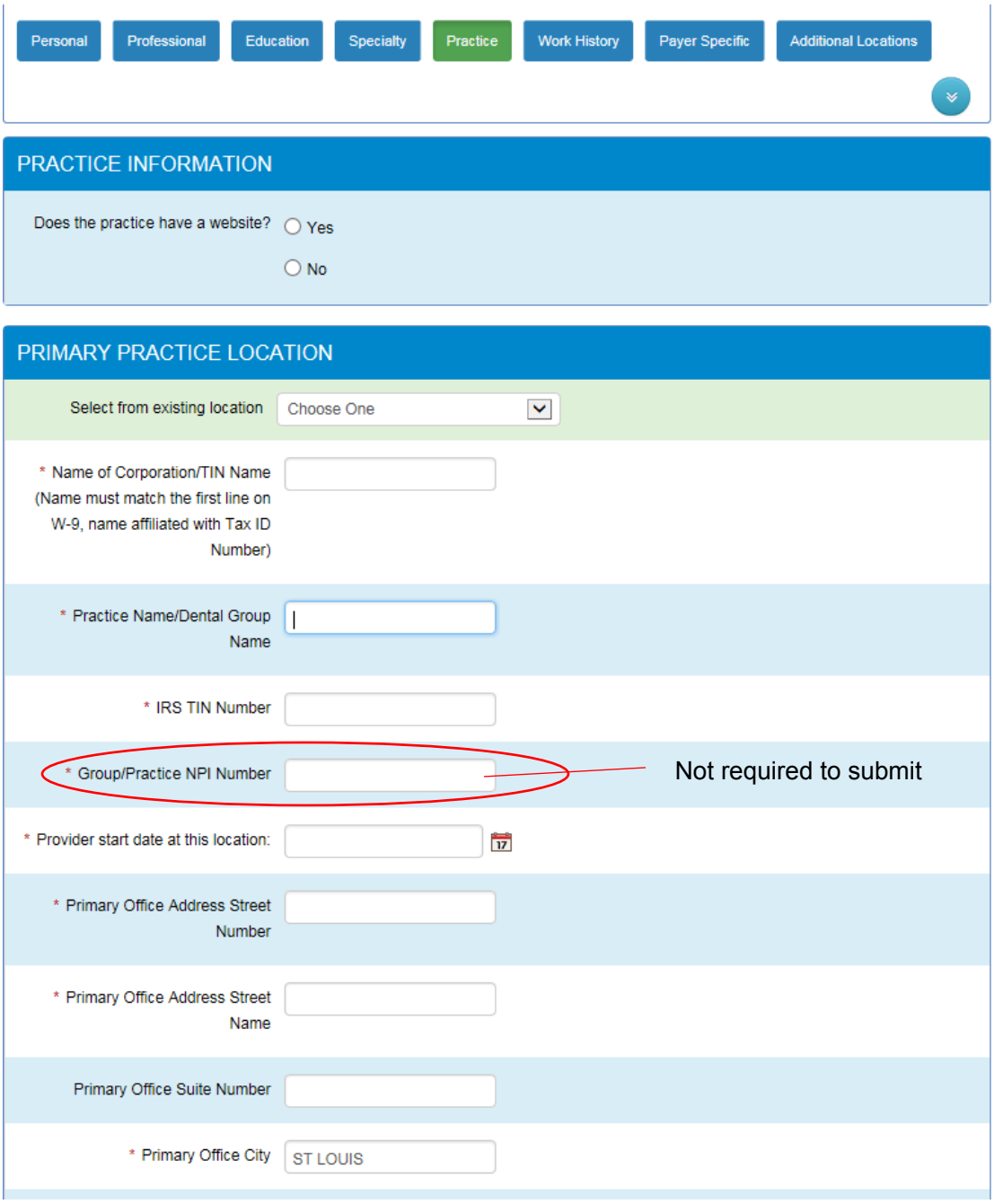
15. The **Education** section of the question wizard.



16. The **specialty** section of the question wizard. The drop down lets you chose your specialty.



17. The **Practice** section of the question wizard. This contains general information regarding your practice.



* Primary Office City [redacted]

* Primary Office State [redacted]

* Primary Office Zip Code [redacted]

* Primary Office Phone Number [redacted]

Primary Office Phone Number Ext

* Primary Office Email Address [redacted]

PAYMENT AND REMITTANCE

* Is your Payment address different from your Primary Location address?
- ○ Yes
- ○ No

OFFICE HOURS

Does your office offer business hours before 8:00 AM?
- ○ Yes
- ○ No

Does your office offer business hours after 5:00 PM?
- ○ Yes
- ○ No

Does the practice have weekend hours?
- ○ Yes
- ○ No

LANGUAGES

* Languages Spoken in the Office (by Both Staff and Provider, including sign language)

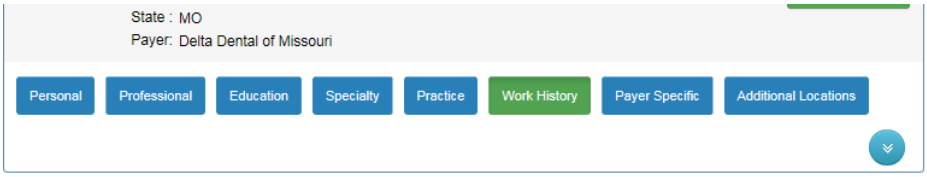
ACCESSIBILITY

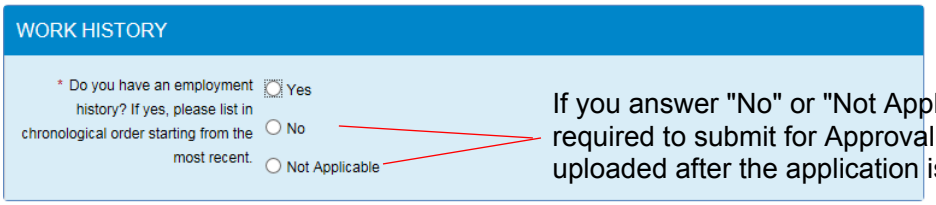
Do you treat disabled adults?
- ○ Yes
- ○ No

Do you treat disabled children?
- ○ Yes
- ○ No

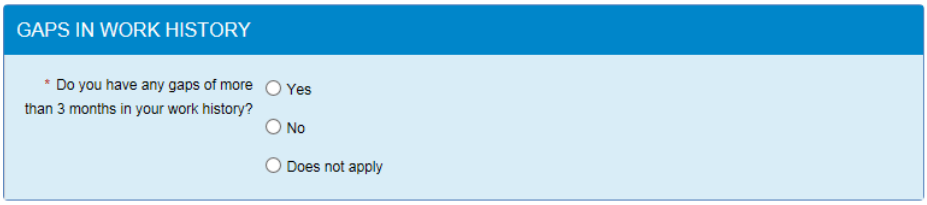
Is your office accessible by public transportation?
- ○ Yes
- ○ No

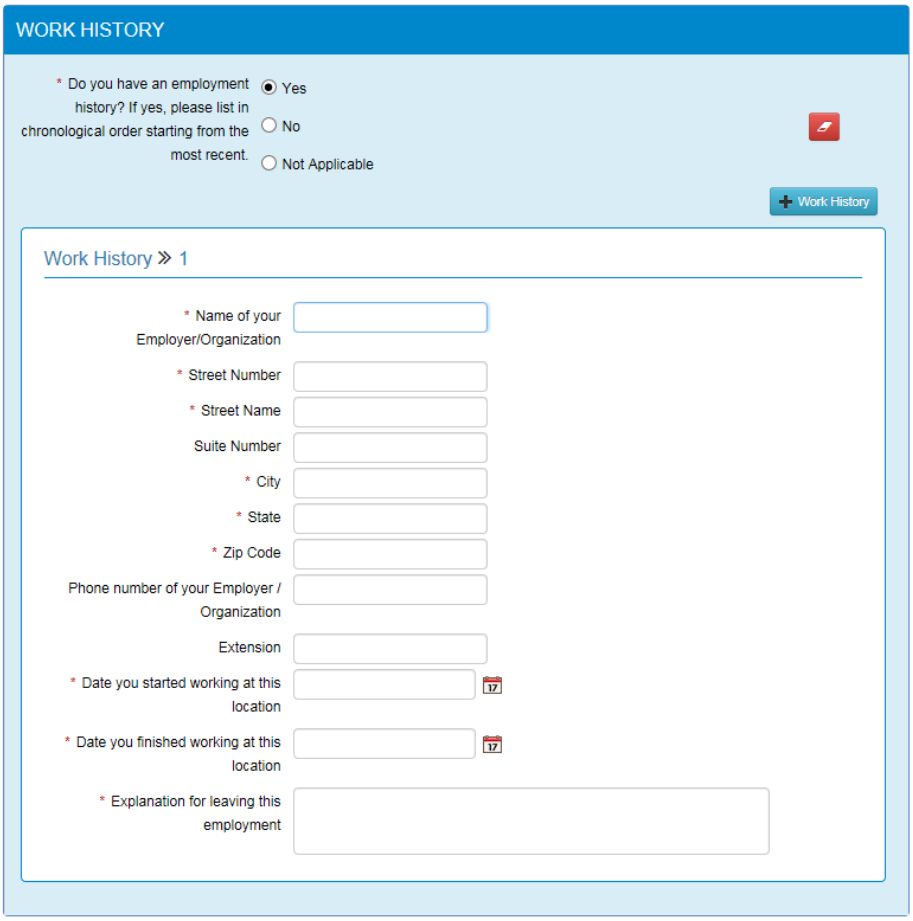
18. The **Work History** section of the question wizard. We require 5 years of work history or a CV resume to submit for Initial and Re-Credentialing providers.





If you answer "No" or "Not Applicable", a CV resume is required to submit for Approval. The CV resume can be uploaded after the application is complete.





GAPS IN WORK HISTORY

* Do you have any gaps of more than 3 months in your work history?

- (•) Yes
- ( ) No
- ( ) Does not apply

Save & Continue →

GAPS IN WORK HISTORY

* Do you have any gaps of more than 3 months in your work history?

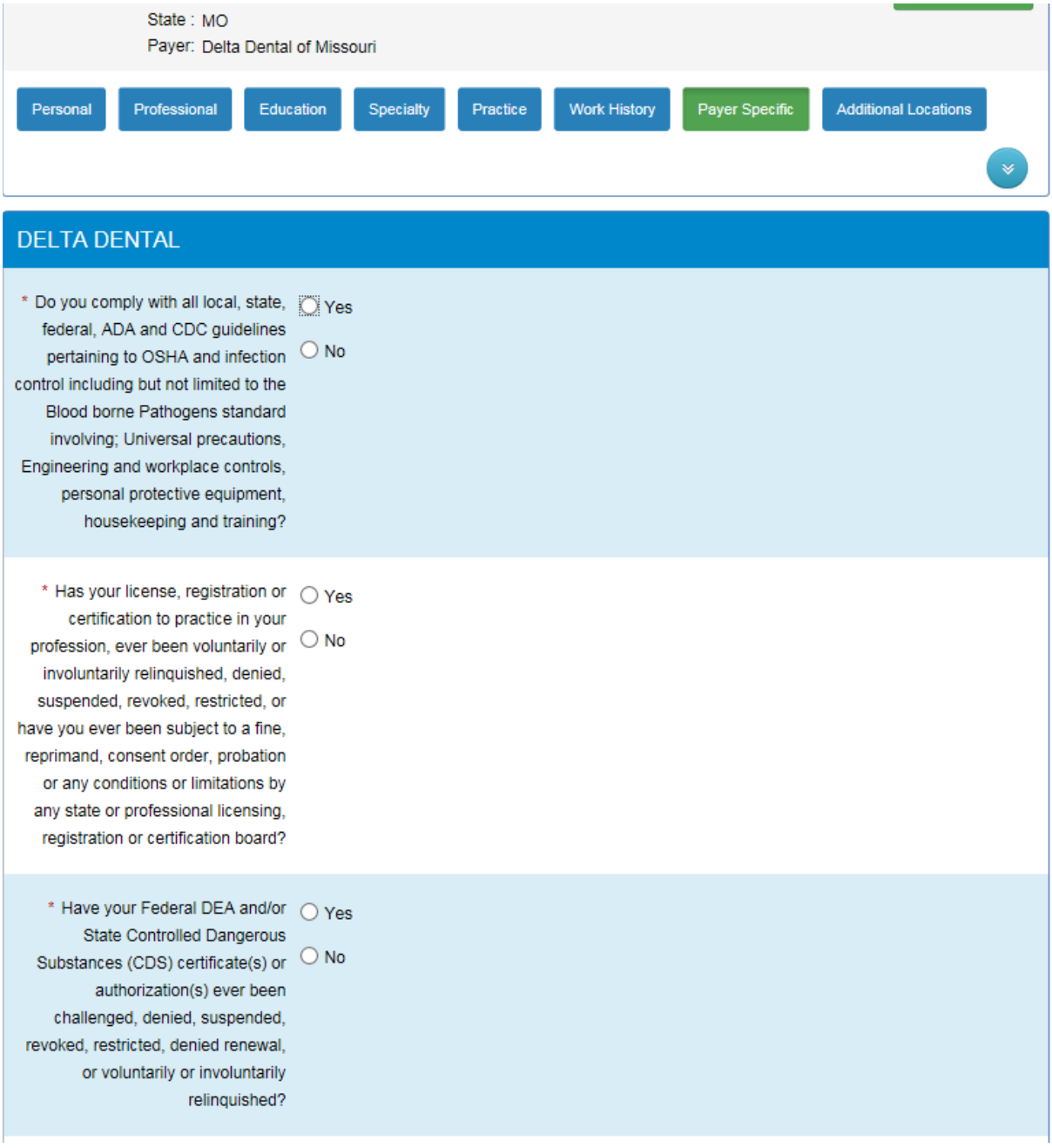
- (•) Yes
- ( ) No
- ( ) Does not apply

Work History Gaps of More than Three Months » 1

* Explain any time periods or gaps in work history

Save & Continue →

19. **Attestation** section. All Attestation's can be answered with a Yes or No.

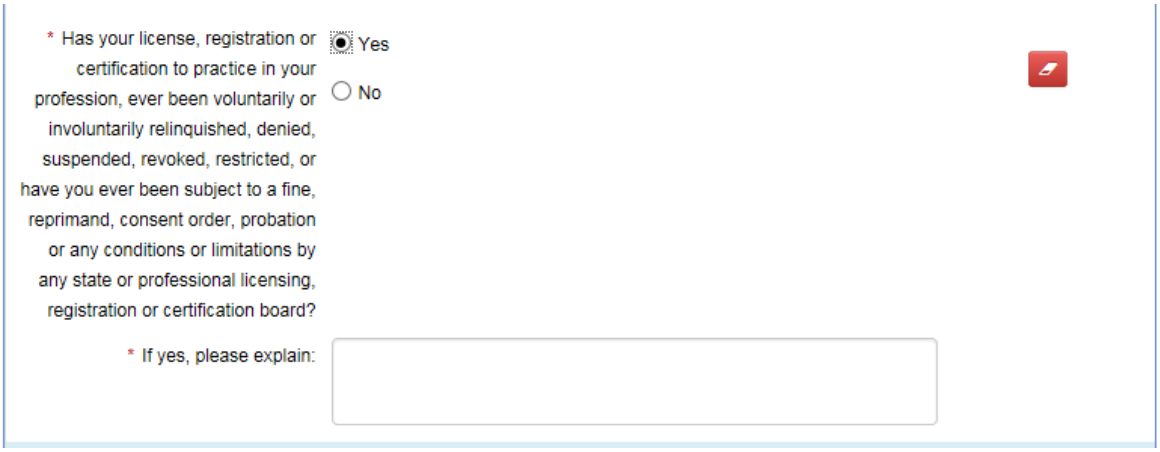


* Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?	◯ Yes ◯ No
* Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?	◯ Yes ◯ No
* To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	◯ Yes ◯ No
* Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?	◯ Yes ◯ No

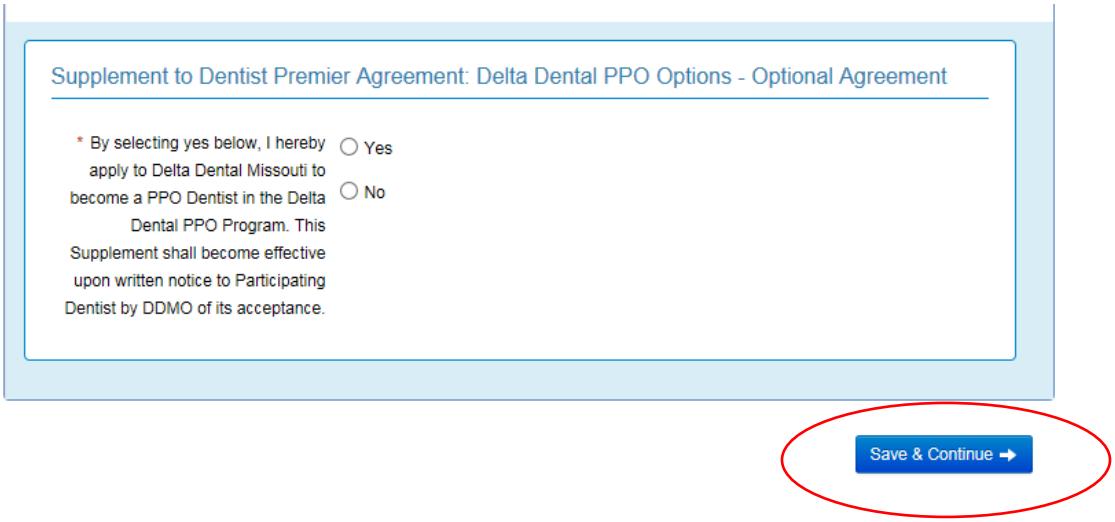
* Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?	◯ Yes ◯ No
* Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?	◯ Yes ◯ No
* Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?	◯ Yes ◯ No
* Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?	◯ Yes ◯ No
* In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?	◯ Yes ◯ No

* Are you currently engaged in the illegal use of drugs?* ('Currently' means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. 'Illegal use of drugs' refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It 'does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law.' The term does include, however, the unlawful use of prescription controlled substances.)	○ Yes ○ No
* Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	○ Yes ○ No
* Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?	○ Yes ○ No
* Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?	○ Yes ○ No

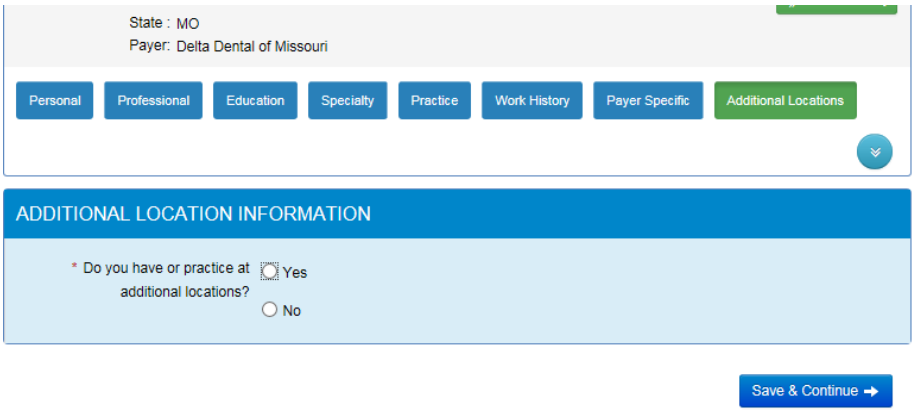
If you answer “Yes” to any of the above questions, a box will pop up asking for further explanation. An explanation is required to submit, this does not mean you will not be allowed in the network.



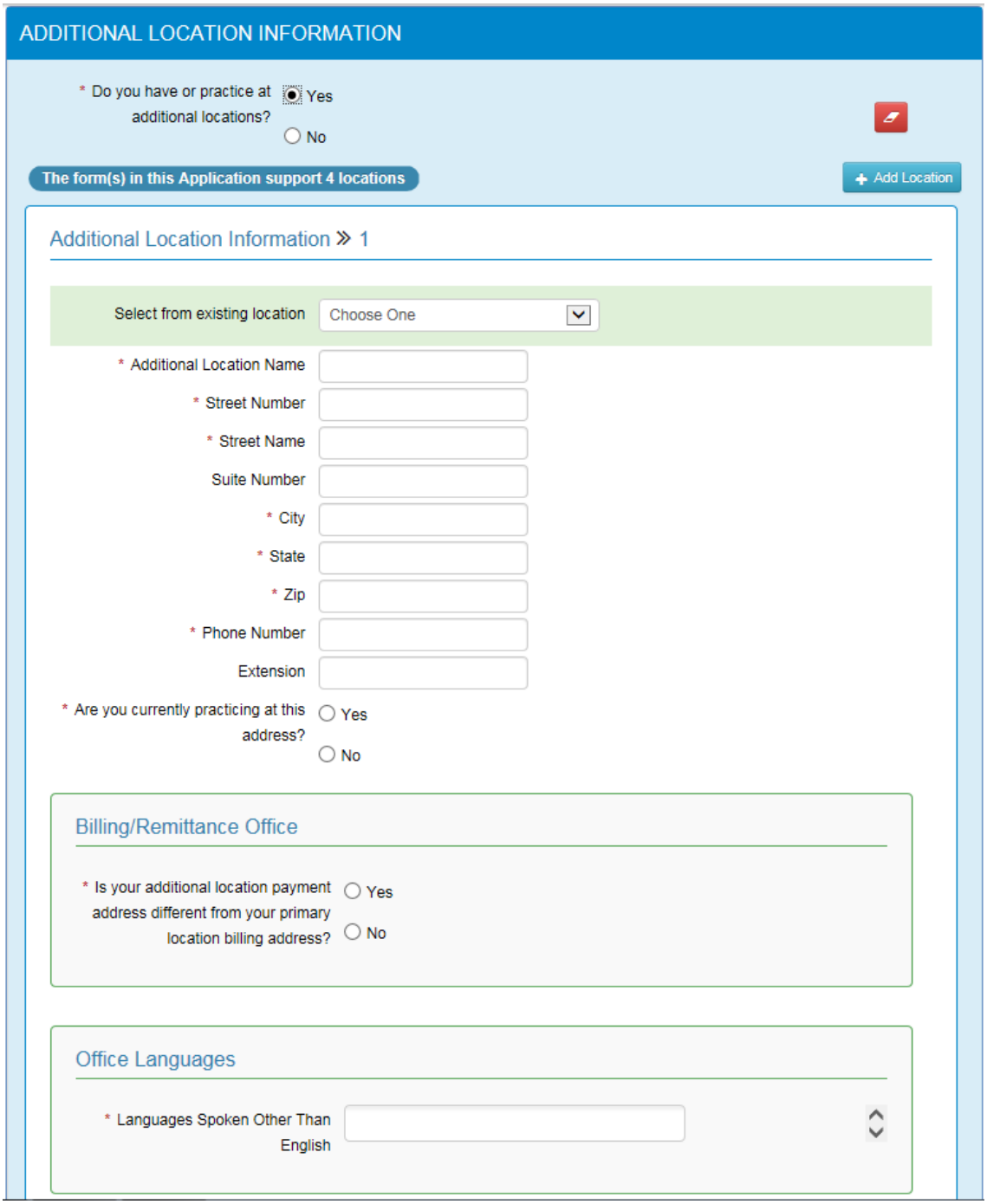
20. PPO agreement – This is **Optional;** If you want to participate in PPO, click “Yes”, if you do not wish to participate in PPO, please click “Save & Continue”.



21. Additional location section

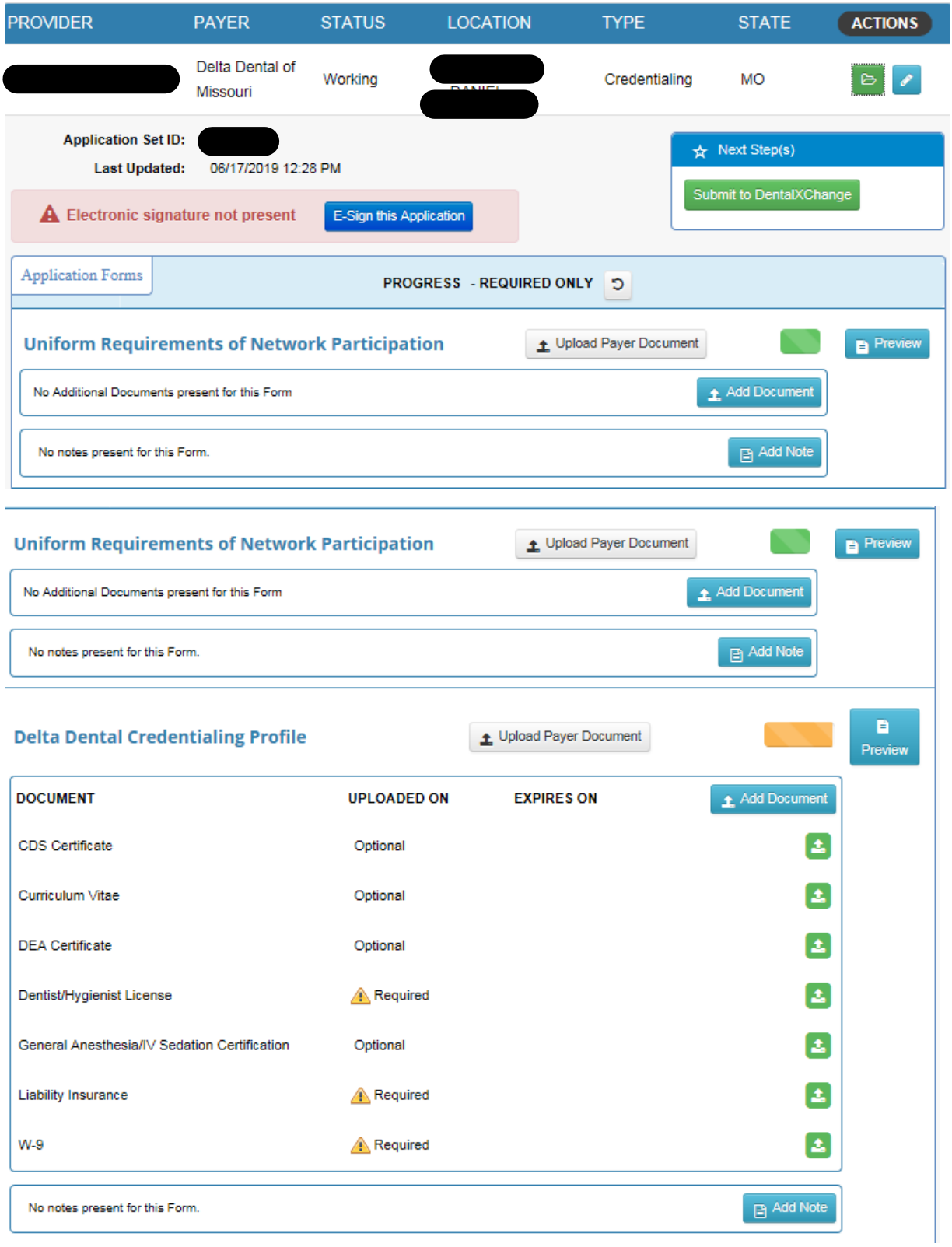


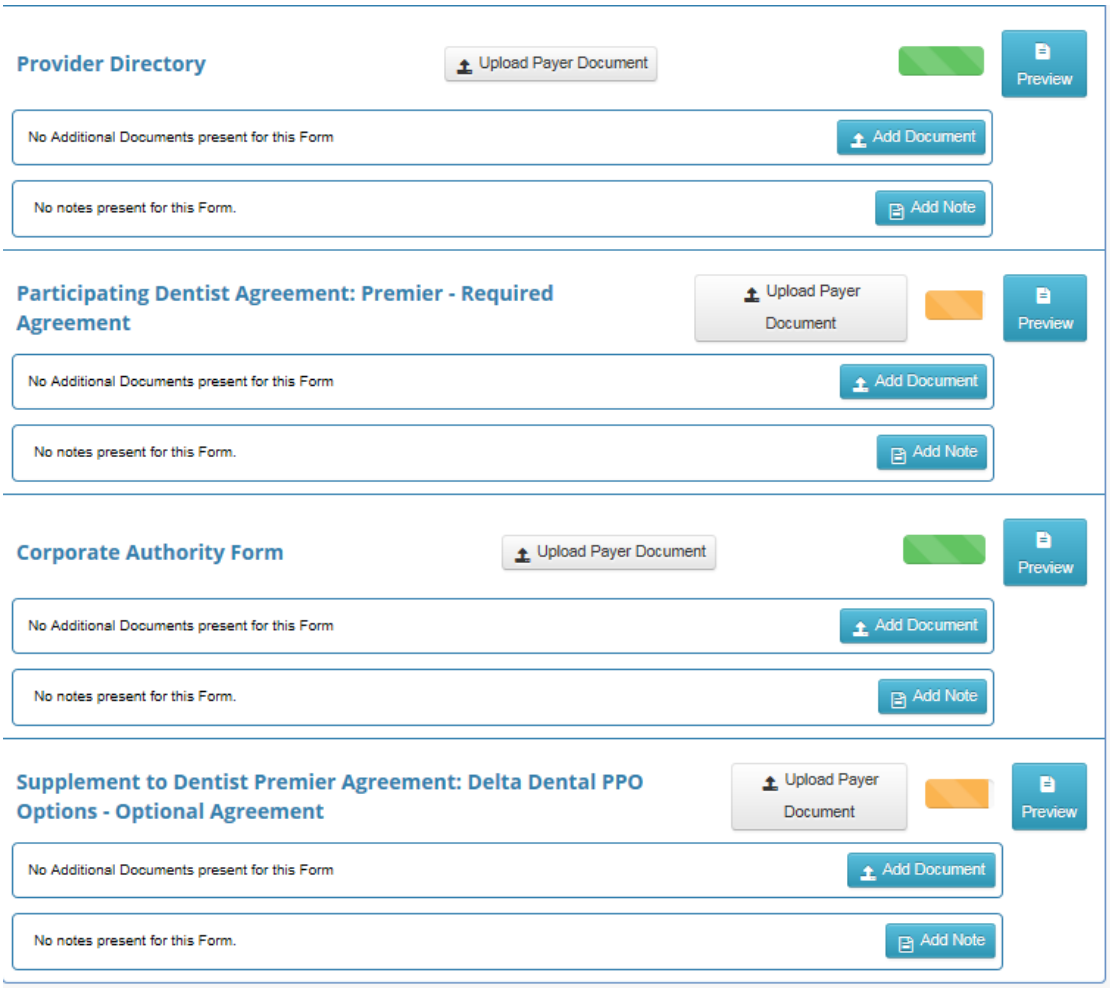
If “Yes” you practice at Additional locations, the below will populate:

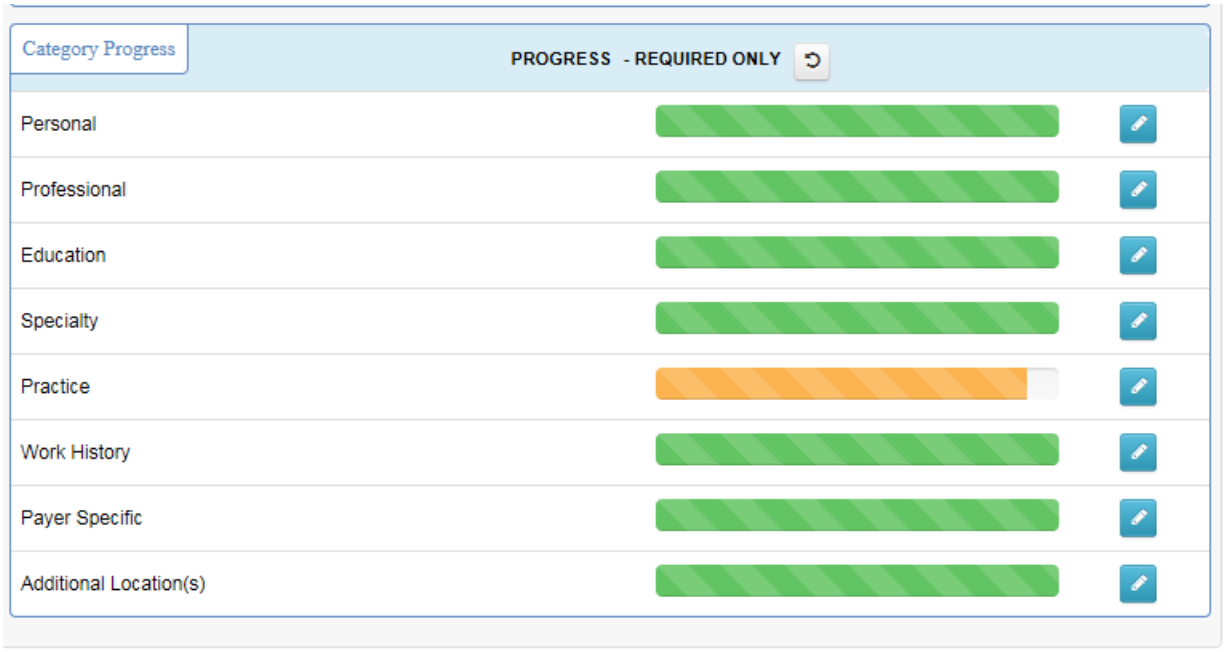


If “No” you do not participate at any other additional locations, you will not need to fill anything else out. Click “Save&Continue”.

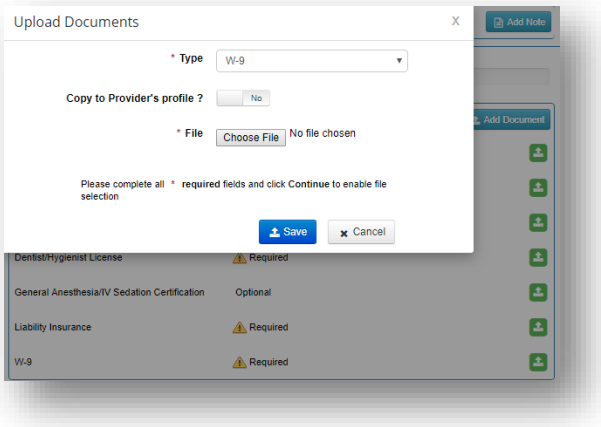
22. Once all categories are answered, you will come to the summary page displayed below. This is also where you can upload any required documents need to submit.



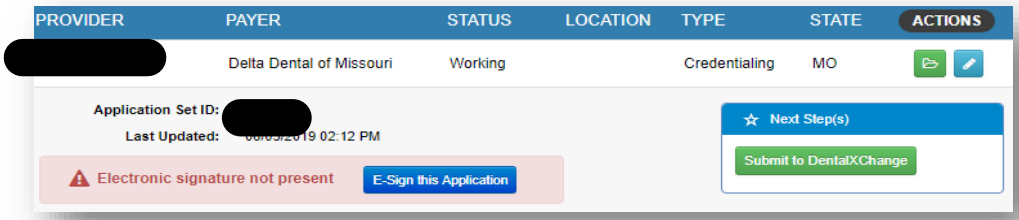

Provider Directory
Upload Payer Document
Preview
No Additional Documents present for this Form
Add Document
No notes present for this Form.
Add Note
Participating Dentist Agreement: Premier - Required Agreement
Upload Payer Document
Preview
No Additional Documents present for this Form
Add Document
No notes present for this Form.
Add Note
Corporate Authority Form
Upload Payer Document
Preview
No Additional Documents present for this Form
Add Document
No notes present for this Form.
Add Note
Supplement to Dentist Premier Agreement: Delta Dental PPO Options - Optional Agreement
Upload Payer Document
Preview
No Additional Documents present for this Form
Add Document
No notes present for this Form.
Add Note


Category Progress
PROGRESS - REQUIRED ONLY
Personal
Professional
Education
Specialty
Practice
Work History
Payer Specific
Additional Location(s)

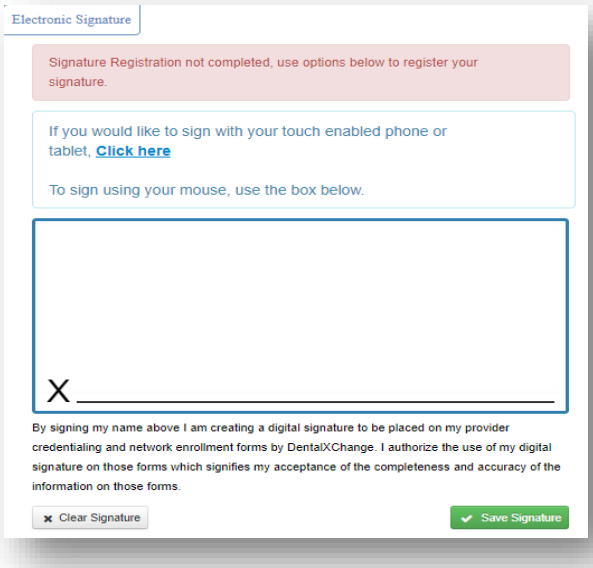
23. Provider can upload required certifications by selecting the green arrow and filling out the required fields marked with a red (*) asterisk:



24. Provider can apply e-signature to their application by selecting the blue E-Sign this Application button at the top of the page:

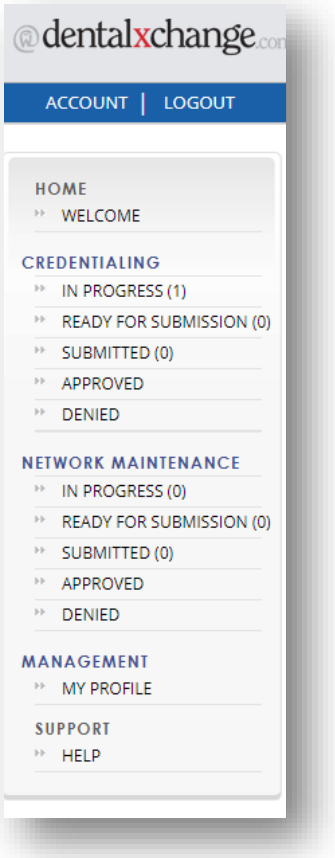


Once the blue **E-Sign this Application** button is selected, they will be directed to a signature box:



The Provider can sign their profile using their mouse or touch enable phone or tablet. Once the provider applies their signature, they have to click on the green **Save Signature** button to store it.

The Provider can also sign their profile by selecting **My Profile** under management



25. Provider accesses application by selecting **In Progress** under Credentialing and clicks on submit to DentalXChange for processing: