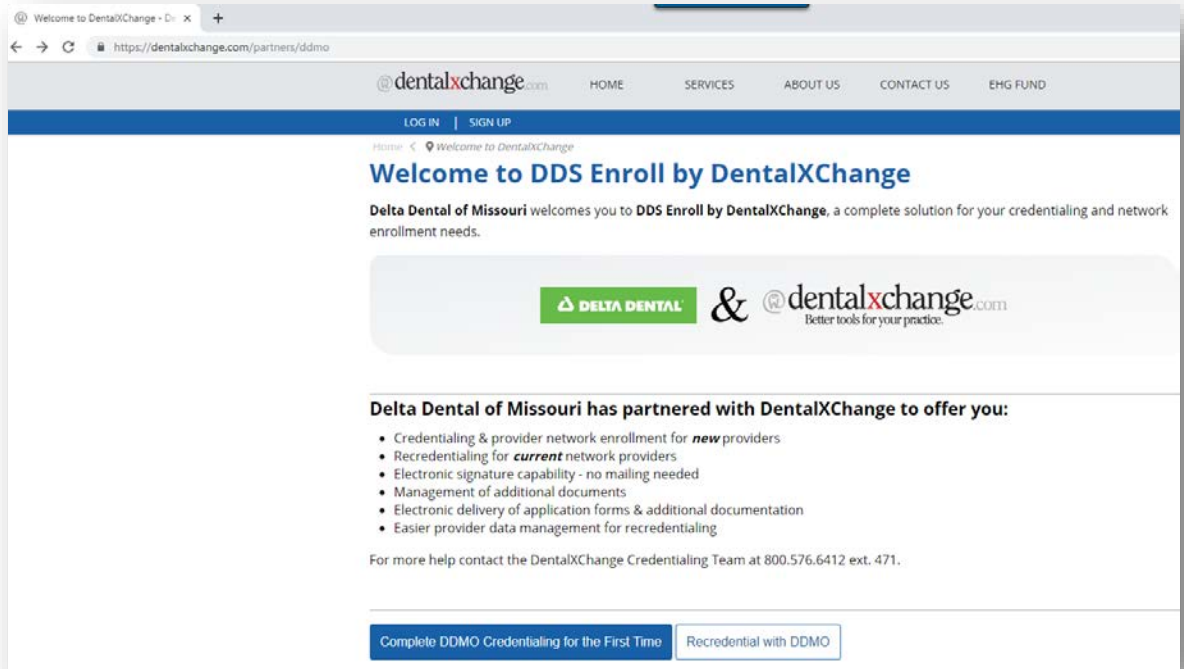


1. Access landing page at www.dentalxchange.com/partners/ddmo for Delta Dental of Missouri Providers or www.dentalxchange.com/partners/ddsc for Delta Delta of South Carolina Providers. The links are also available on Delta Dental's website to be directed to Dental Xchange.
2. Once you are at the landing 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**.

The screenshot shows the "Delta Dental of Missouri Registration for DDS Enroll" form. At the top, there is a navigation bar with the DentalXChange logo and links for HOME, SERVICES, ABOUT US, and CONTACT US. On the left side, there is a contact box for DentalXChange: "Contact DentalXChange", "A Credentialing Specialist is ready to help!", "800.576.6412 Ext.471", and "Monday thru Friday 7AM - 5PM PST". The main form area has a heading "Delta Dental of Missouri Registration for DDS Enroll" and a sub-heading "Please enter the information below to find the Provider in our system." Below this is a "Find Provider" section with two required fields: "Provider's Individual NPI" (with a "Provider NPI" input field) and "Provider's Last Name" (with a "Last Name" input field). At the bottom left, there is a link: "Need help? [Click Here](#) for the Quick Start Guide". At the bottom right, there is a blue "Find Provider" button.

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

DentalXChange Login

PayConnect Login

DentalXChange Services

* Username

* Password

Remember my username

Log In

Sign Up!

New customer? Please register with DentalXChange to add new services. Electronically submit claims, send attachments and retrieve eligibility and benefits with **Claim Services**. Streamline provider data for secure online payer delivery with **Credentialing Services**. Obtain credit score checks with **FICO Services**. Help patients stay connected with your practice with **Patient Services**.

Forgot your username or password?

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

1 2 3 4 5 6 ?

Contact DentalXChange

An Account Executive is ready to help!

800.576.6412 Ext.455

Monday thru Friday
7AM - 5PM PST

Welcome to the *DentalXChange Worry-Free Registration*

For a Worry-Free experience, please provide us with your information and click "Continue".

You can access our "Get Help" button after the below information is completed, our Account Executives can assist you more efficiently after receiving this information.

All fields are Required. Click the "Continue" button once the form is completed.

Already have a DentalXChange Account? Log In

Login Information

* First Name

* Last Name

* Phone

* E-mail

* Username

* Password

* Confirm Password

In order to comply with HIPAA standards and protect your patients' health information, we require that you change your password every 90 days.

I'm not a robot

reCAPTCHA
Privacy · Terms

* Required Fields

> CONTINUE

6. **New Provider** enters Practice Information:

dentalexchange.com DASHBOARD SERVICES ABOUT US CONTACT US

LOGOUT

1 2 3 4 5 6 ?

Contact DentalXChange

An Account Executive is ready to help!

800.576.6412 Ext.455

Monday thru Friday
7AM - 5PM PST

Practice Profile

* Practice Name Practice name required

* Address Line 1

Address Line 2

* City

* State Choose One

* Zip

* Practice Phone Phone required

Extension

Fax

* Practice E-mail

* Are you a Dentist/Hygienist at this Practice? Yes No

* Required Fields

> CONTINUE

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

Dentist Information

* First Name

* Last Name

* Specialty Choose One

* TIN SSN

Billing NPI

Rendering NPI

* Required Fields

> CONTINUE

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

The screenshot shows the registration process on dentalxchange.com. At the top, there is a navigation bar with the logo and links for DASHBOARD, SERVICES, ABOUT US, and CONTACT US. Below this is a blue bar with a LOGOUT link. A progress indicator at the top shows six steps, with step 2 highlighted in green and step 3 marked with a red square. A sidebar on the left titled "Registered Solutions" contains the text "You have not Registered for any Services". The main content area has a blue box with the text: "This step is optional. If you do use a Practice Management System, please select the correct one so that we can offer you any special pricing and promotions available at this time." Below this is a "Select Your System" section with a "Current Selection" dropdown menu set to "No Practice Management System". A red "CONTINUE" button is located at the bottom right.

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

The screenshot shows the registration process on dentalxchange.com, step 4. The progress indicator at the top shows six steps, with step 4 highlighted in green and step 3 marked with a red square. A sidebar on the left titled "Registered Solutions" contains the text "You have not Registered for any Services". The main content area has a blue box with the text: "This step is optional. If you do use a Practice Management System, please select the correct one so that we can offer you any special pricing and promotions available at this time." Below this is a "DentalXChange Direct Packages" section. It features a "Have a Promotion Code?" field with an "Apply Code" button and a "Service Selection" button. A dropdown menu is open, showing "Delta Dental of Missouri Credentialing" with a radio button selected and circled in red. A "Claim Solution" button is to the right of the dropdown. A red "CONTINUE" button is located at the bottom right.

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

The screenshot shows the DentalXChange.com dashboard. At the top, there are navigation links for DASHBOARD, SERVICES, ABOUT US, and CONTACT US, along with a user profile icon. Below the navigation is a blue bar with a LOGOUT link. A progress indicator at the top shows six steps, with step 4 highlighted in red and a green checkmark in a bubble. Below the progress bar, there is a 'Registered Solutions' section on the left with the text 'You have not Registered for any Services'. In the center, there is a 'Have a Promotion Code?' field with an 'Apply Code' button and a 'Service Selection' button. The main content area is titled 'DentalXChange Direct Packages' and contains a list of services. The first service, 'Delta Dental of Missouri Credentialing', is selected and has a green checkmark in a bubble. A tooltip points to the checkmark with the text 'Click to Add Delta Dental of Missouri Credentialing to your selection'. To the right of the service name is a 'Claim Solution' button. At the bottom right, there is a '> CONTINUE' button.

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

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

The screenshot shows the DentalXChange.com dashboard. At the top, there are navigation links for DASHBOARD, SERVICES, ABOUT US, and CONTACT US, along with a user profile icon. Below the navigation is a blue bar with a LOGOUT link. A progress indicator at the top shows six steps, with step 6 highlighted in red. Below the progress bar, there is an 'Unconfirmed Packages' section on the left with the text 'Delta Dental Of Missouri Credentialing'. Below that is a 'Registered Solutions' section with the text 'You have not Registered for any Services'. The main content area is titled 'Services Being Confirmed' and contains a box for 'Delta Dental of Missouri Credentialing'. Inside this box, it says 'Electronic Credentialing Application Submission to Delta Dental of Missouri.' followed by '* FREE submission of Application forms and related documents'. Below this, it says 'Includes the following features:' and lists four items: 'Provider Credentialing Management', 'Network application submission to payers', 'Credentialing provider profile', and 'Credentialing provider profile activation'. Below the box, there is a 'Notices:' section with four bullet points: 'EHG will make its best effort to deliver transactions to their intended recipients in a secure and timely manner.', 'EHG's liability is limited to the resubmission of the transaction(s) in question.', 'The minimum monthly charge for any combination of packages that have a fee associated to it is \$9.95.', and 'Charges, if applicable, will appear on your credit card/bank statement as *DentalXChange*.'. At the bottom, there are three buttons: '< CHANGE SELECTION', '< I DISAGREE', and '> I AGREE'.

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.

ACCOUNT | LOGOUT CLAIM SERVICES FINANCIAL SERVICES PATIENT SERVICES

HOME
» WELCOME

CREDENTIALING
» IN PROGRESS (0)
» READY FOR SUBMISSION (0)
» SUBMITTED (0)
» APPROVED
» DENIED

NETWORK MAINTENANCE
» IN PROGRESS (0)
» READY FOR SUBMISSION (0)
» SUBMITTED (0)
» APPROVED
» DENIED

MANAGEMENT
» MY PROFILE

SUPPORT
» HELP

Credentialing » Start Applications ?

* Form

* Provider

* State

* Payers

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.

State : MO
Payer: Delta Dental of Missouri

Personal Professional Education Specialty Practice Work History Payer Specific Additional Locations

NAME


* Legal First Name

Legal Middle Name

* Legal Last Name

GENERAL INFORMATION

* Gender

* Date of Birth 

* SSN

HOME ADDRESS

Home Address Information

Home Address Street Number

Street Name

Suite/Apt/Building Number

City

State

Zip Code


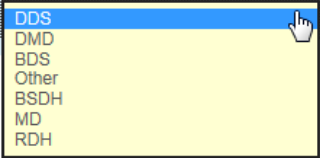
14. The **Professional** section of the question wizard.

PROFESSIONAL IDS

* Provider Degree/Title

* Do you have a Dental/Medical License?

DDS
DMD
BDS
Other
BSDH
MD
RDH




PROFESSIONAL IDS

* Provider Degree/Title

* Do you have a Dental/Medical License? Yes No

Dental/Medical License Information » 1


* Dental/Medical License Number



OTHER ID NUMBERS

* Do you have an assigned NPI Number? Yes No

* Individual Provider NPI Number



Save & Continue →

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

Credentialing » Education

Dentist Name: [REDACTED] > View Summary

State : MO
Payer: Delta Dental of Missouri

[Personal](#) [Professional](#) [Education](#) [Specialty](#) [Practice](#) [Work History](#) [Payer Specific](#) [Additional Locations](#)

⌵

DENTAL/MEDICAL/PROFESSIONAL SCHOOL

* Did you complete Dental or Hygienist School Training? Yes
 No

Save & Continue →

State : MO
Payer: Delta Dental of Missouri

[Personal](#) [Professional](#) [Education](#) [Specialty](#) [Practice](#) [Work History](#) [Payer Specific](#) [Additional Locations](#)


⌵

DENTAL/MEDICAL/PROFESSIONAL SCHOOL

* Did you complete Dental or Hygienist School Training? Yes No ✖

Dental/Medical School Information » 1

* Dental/Medical School Name

* Graduation Date 

Save & Continue →

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

State : MO
Payer: Delta Dental of Missouri

Personal Professional Education **Specialty** Practice Work History Payer Specific Additional Locations

⌵

PRIMARY SPECIALTY

* Select Primary Specialty

Save & Continue →

State : MO
Payer: Delta Dental of Missouri

Personal Professional Education **Specialty** Practice Work History Payer Specific Additional Locations

⌵

PRIMARY SPECIALTY

* Select Primary Specialty

- Choose One
- Advanced Dental Therapist
- Anesthesiology
- Dental Health Aid Therapist
- Dental Public Health
- Dental Therapist
- Dentist
- Denturist
- Endodontist
- General Dentist
- Oral and Maxillofacial Pathology
- Oral and Maxillofacial Radiology
- Oral and Maxillofacial Surgery
- Orthodontics and Dentofacial Orthopedics
- Other
- Pediatric Dentistry
- Periodontist
- Prosthodontist
- Public Health
- Registered Dental Hygenist
- CRNA

Save & Continue →

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

Personal Professional Education Specialty **Practice** Work History Payer Specific Additional Locations

PRACTICE INFORMATION

Does the practice have a website? Yes
 No

PRIMARY PRACTICE LOCATION

Select from existing location Choose One

* Name of Corporation/TIN Name (Name must match the first line on W-9, name affiliated with Tax ID Number)

* Practice Name/Dental Group Name

* IRS TIN Number

* Group/Practice NPI Number Not required to submit

* Provider start date at this location:

* Primary Office Address Street Number

* Primary Office Address Street Name

Primary Office Suite Number

* Primary Office City ST LOUIS

* Primary Office City

* Primary Office State

* Primary Office Zip Code

* Primary Office Phone Number

Primary Office Phone Number Ext

* Primary Office Email Address

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.

State : MO
Payer: Delta Dental of Missouri

Personal Professional Education Specialty Practice **Work History** Payer Specific Additional Locations

WORK HISTORY

* Do you have an employment history? If yes, please list in chronological order starting from the most recent. Yes No Not Applicable

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 →

WORK HISTORY

* Do you have an employment history? If yes, please list in chronological order starting from the most recent. Yes No Not Applicable

+ Work History

Work History » 1

* Name of your Employer/Organization

* Street Number

* Street Name

Suite Number

* City

* State

* Zip Code

Phone number of your Employer / Organization

Extension

* Date you started working at this location 17

* Date you finished working at this location 17

* Explanation for leaving this employment

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.

State : MO
Payer: Delta Dental of Missouri

Personal Professional Education Specialty Practice Work History **Payer Specific** Additional Locations



DELTA DENTAL

* Do you comply with all local, state, federal, ADA and CDC guidelines pertaining to OSHA and infection control including but not limited to the Blood borne Pathogens standard involving; Universal precautions, Engineering and workplace controls, personal protective equipment, housekeeping and training? Yes No

* Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? Yes No

* Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? Yes 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.

* Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?

Yes No

* If yes, please explain:

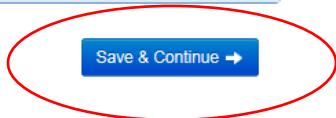


20. PPO agreement – This is **Optional**; If you want to participate in PPO, click “Yes”, if you do not wish to participate in PPO, please click “Save & Continue”.

Supplement to Dentist Premier Agreement: Delta Dental PPO Options - Optional Agreement

* By selecting yes below, I hereby apply to Delta Dental Missouri to become a PPO Dentist in the Delta Dental PPO Program. This Supplement shall become effective upon written notice to Participating Dentist by DDMO of its acceptance.

Yes No



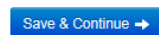
21. Additional location section

State : MO
Payer: Delta Dental of Missouri

Personal Professional Education Specialty Practice Work History Payer Specific **Additional Locations**

ADDITIONAL LOCATION INFORMATION

* Do you have or practice at additional locations? Yes No



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

ADDITIONAL LOCATION INFORMATION

* Do you have or practice at Yes additional locations? No

The form(s) in this Application support 4 locations [+ Add Location](#)

Additional Location Information >> 1

Select from existing location

* Additional Location Name

* Street Number

* Street Name

Suite Number

* City

* State

* Zip

* Phone Number

Extension

* Are you currently practicing at this address? Yes No

Billing/Remittance Office

* Is your additional location payment address different from your primary location billing address? Yes No

Office Languages

* Languages Spoken Other Than English

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	PAYER	STATUS	LOCATION	TYPE	STATE	ACTIONS
[REDACTED]	Delta Dental of Missouri	Working	[REDACTED]	Credentialing	MO	

Application Set ID: [REDACTED]
Last Updated: 06/17/2019 12:28 PM

Electronic signature not present [E-Sign this Application](#)

[Next Step\(s\)](#)
[Submit to DentalXChange](#)

Application Forms PROGRESS - REQUIRED ONLY

Uniform Requirements of Network Participation

[Upload Payer Document](#) [Preview](#)

No Additional Documents present for this Form [Add Document](#)

No notes present for this Form. [Add Note](#)

Uniform Requirements of Network Participation

[Upload Payer Document](#) [Preview](#)

No Additional Documents present for this Form [Add Document](#)

No notes present for this Form. [Add Note](#)

Delta Dental Credentialing Profile

[Upload Payer Document](#) [Preview](#)

DOCUMENT	UPLOADED ON	EXPIRES ON	Add Document
CDS Certificate	Optional		
Curriculum Vitae	Optional		
DEA Certificate	Optional		
Dentist/Hygienist License	Required		
General Anesthesia/IV Sedation Certification	Optional		
Liability Insurance	Required		
W-9	Required		

No notes present for this Form. [Add Note](#)

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:

Certification	Requirement
Dentist/Hygienist License	Required
General Anesthesia/IV Sedation Certification	Optional
Liability Insurance	Required
W-9	Required

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

PROVIDER	PAYER	STATUS	LOCATION	TYPE	STATE	ACTIONS
[Redacted]	Delta Dental of Missouri	Working		Credentialing	MO	[Envelope Icon] [Pencil Icon]

Application Set ID: [Redacted]
Last Updated: 06/05/2019 02:12 PM

Electronic signature not present [E-Sign this Application]

Next Step(s)
[Submit to DentalXChange]

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

Signature Registration not completed, use options below to register your signature.

If you would like to sign with your touch enabled phone or tablet, [Click here](#)

To sign using your mouse, use the box below.

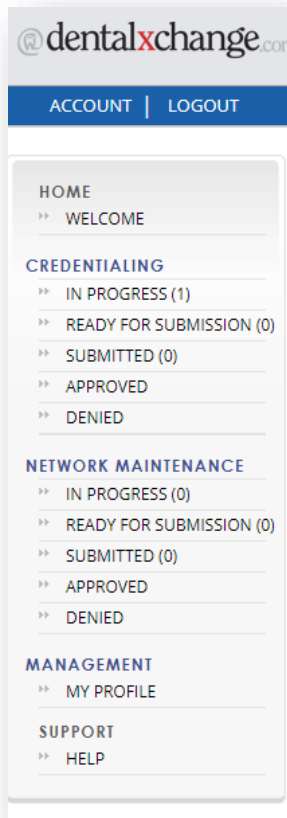
X _____

By signing my name above I am creating a digital signature to be placed on my provider credentialing and network enrollment forms by DentalXChange. I authorize the use of my digital signature on those forms which signifies my acceptance of the completeness and accuracy of the information on those forms.

[Clear Signature] [Save Signature]

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:

