



**MEDICAL
PROTECTIVE**

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DENTAL POLICY CHANGE REQUEST

Policy # _____

Please Fax or E-Mail Application: 800-398-6726 / dental@medpro.com
If you have questions, please contact your agent or call 1-800-4-MedPro

DENTAL POLICY CHANGE REQUEST



I. GENERAL INFORMATION

Please print legibly. Please answer all questions. If a question is not applicable, state "N/A".

A. Requested Effective Date of Change: (MM/DD/YYYY) _____ 12:01 a.m.

B. General Information:

Last Name _____ First Name _____ M.I. _____ Suffix _____

Date of Birth (MM/DD/YYYY) _____ Social Security Number (Optional) _____

National Provider Identifier (NPI) _____

E-Mail _____

Business Fax _____ Business Phone _____ Residence/Cell Phone _____

C. Practice Location(s):

(Please list principal location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. Primary Location:

% of Practice _____ Type of Location: Hospital Office Residence

Location Name _____

Number and Street _____ Suite _____

City _____ County _____ State _____ Zip Code _____

2. Additional Location:

% of Practice _____ Type of Location: Hospital Office Residence

Location Name _____

Number and Street _____ Suite _____

City _____ County _____ State _____ Zip Code _____

D. Preferred Billing and Correspondence Address:

Location Number (From Section C. above) _____ Other (please enter below)

Number and Street _____ Suite _____

City _____ State _____ Zip Code _____

II. PRACTICE INFORMATION

A. States in which you hold a license to practice dentistry:

Please check the appropriate box to indicate the status of your license. Exclude state abbreviation from license number.

- | | Active | Inactive | Temporary | Pending |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. State _____ License # _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. State _____ License # _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DEA License? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

III. RATING INFORMATION

A. Please indicate the estimated average weekly numbers, under each of the following categories, for which you require Medical Protective coverage: (If none, please enter '0' in the space provided.)

Patients Per Week _____ Hours Per Week _____ Unscheduled New Walk-In Patients Per Week _____

B. Please check your present specialty:

- | | | |
|--|---|---|
| <input type="checkbox"/> General Dentist | <input type="checkbox"/> Prosthodontist | <input type="checkbox"/> Oral & Maxillofacial Surgeon |
| <input type="checkbox"/> Orthodontist | <input type="checkbox"/> Oral Pathologist | <input type="checkbox"/> Dual Degree |
| <input type="checkbox"/> Pediatric Dentist | <input type="checkbox"/> Dental Anesthesiologist | <input type="checkbox"/> Board Certified |
| <input type="checkbox"/> Endodontist | <input type="checkbox"/> Pain Management (Please explain) _____ | Date of Certification (MM/YYYY) _____ |
| <input type="checkbox"/> Periodontist | <input type="checkbox"/> Other (Please explain) _____ | |

C. Please check procedures you will perform in your practice:

- | | |
|---|---|
| <input type="checkbox"/> Orthodontic Full Mouth Banding
Year you began this procedure (YYYY) _____ | <input type="checkbox"/> Sinus Lifts |
| <input type="checkbox"/> Placement of Mini Implants for Orthodontic/Prosthesis | <input type="checkbox"/> Palatal Inserts
Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Implant Prosthesis/Supported Prosthesis | <input type="checkbox"/> Nerve Grafts |
| <input type="checkbox"/> Sargenti Root Canal Method Utilizing N2 or Similar Paste | <input type="checkbox"/> Cleft Lip and Palate Surgery |
| <input type="checkbox"/> Surgical Placement of Implant Fixtures
Year you began this procedure (YYYY) _____ | <input type="checkbox"/> Face Lifts |
| <input type="checkbox"/> Botox, Dermal Fillers (i.e. Injections) | <input type="checkbox"/> Management of Malignant Lesions |
| <input type="checkbox"/> Cosmetic Full Mouth Rehabilitation | <input type="checkbox"/> Orthognathic Surgery |
| <input type="checkbox"/> Alternative (Holistic) Dentistry/Medicine
Please explain _____ | <input type="checkbox"/> Rhinoplasty |
| <input type="checkbox"/> Sleep Apnea Therapy
Do you treat only after a physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Skin Peels |
| <input type="checkbox"/> Obesity/Weight Control Treatment | <input type="checkbox"/> Spa Services
Please explain _____ |
| Third Molar Extractions (CPT/CDT Codes) | <input type="checkbox"/> TMJ Surgery |
| <input type="checkbox"/> Erupted (D7110, D7120, D7210)
Year you began this procedure (YYYY) _____ | <input type="checkbox"/> Arthroscopy |
| <input type="checkbox"/> Partially Impacted (D7220, D7230)
Year you began this procedure (YYYY) _____ | <input type="checkbox"/> Implant |
| <input type="checkbox"/> Fully Impacted (D7240, D7241, D7250)
Year you began this procedure (YYYY) _____ | <input type="checkbox"/> Reconstruction |
| | <input type="checkbox"/> Trigger Point Injections |
| | <input type="checkbox"/> Other
Please explain _____ |

D. Indicate the percentage of your practice devoted to the following procedures:

(Total does not have to equal 100%)

- ____ % Denture Procedures Same Day or Economy Replacement Relines
- ____ % Oral Surgery Procedures (i.e. extractions, removal of cysts, etc.)
- ____ % Elective Facial Cosmetic Surgical Procedures (including rhinoplasty, face-lifts, skin grafts, botox, dermal fillers, tattooing, etc.)
- ____ % Reconstructive Cosmetic Surgical Procedures (i.e. cancerous lesion, facial reconstruction, cleft lip/palate, etc.)
- ____ % Procedures performed outside of the oral and maxillofacial region (except bone harvesting procedures)

V. ANESTHESIA INFORMATION

A. As defined below, please "X" if you, an employee or independent contractor treat patients under:

- Conscious Sedation Utilizing CPT/CDT Code D09241 and D09242 - (excluding nitrous oxide) a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.
- IM/IV Oral
- General Anesthesia Utilizing CPT/CDT Code D09220- (to include deep sedation) a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

If Conscious Sedation or General Anesthesia were checked, please complete the Anesthesia Supplement.

B. Please "X" here if this section does not apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar nonscheduled drug) or nitrous oxide only.

VI. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds?

Yes No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to The Medical Protective Company's home office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Name _____

Number and Street _____ Suite _____

City _____ State _____ Zip _____ Phone Number _____

Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

VII. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (**hereinafter "Attachments"**) for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other dentist, physician, firm, or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that **if I fail to comply with these terms I will have no coverage for any claim** under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Signature _____ Date Signed _____

Type or Print Name _____

