

PROSPECTIVE PROVIDER FORM

Legal Business Name: _____

Clinic Name/DBA: _____

TIN: _____ Org/Billing NPI: _____

Owner/Provider: _____ NPI: _____

Primary Office Contact: _____

Office Address: _____

City: _____ State: _____ Zip Code+4: _____

Office Phone: _____ Office Fax: _____

Contact E-mail: _____

Web Address: _____

Provider Type (circle one): General Dentist Pedo Perio Endo Oral Surgeon Denturist EPDH
Organization Type: Sole Proprietorship Partnership LLC PC Other: _____

For additional clinic providers, submit a list with provider full names, degree, and NPI.

OFFICE HOURS: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

Community Outreach such as delivering services in alternate setting such as schools, Head Start programs, Nursing Homes etc. requires Capitol Dental Care approval of these activities and locations as a condition of payment consideration. Are you requesting to participate in community outreach?

Yes ___ No ___ **If yes**, please explain the activity and indicate the outreach location(s):

Will you be providing dental treatment in your office using **general anesthesia or I.V. or conscious sedation**?

Yes ___ No ___ **If yes**, have you notified the Oregon Board of Dentistry? Yes ___ No ___

Will you be administering the sedation? Yes ___ No ___ **If no**, please indicate provider administering sedation:

Is your office accepting **new patients**? Yes ___ No ___ **If no**, please identify any limitations:

Do you have patient **age limitations**? Yes ___ No ___ **If yes**, please identify limitation: _____

Will you see **special needs** patients? Yes ___ No ___ **If yes**, please identify any limitations:

Does the office provide care using seclusion or restraint? Yes _____ No _____

If yes, please provide a copy of your consent form when returning the completed credentialing packet.

Due to new federal regulations, we are required to include information about ADA accessibility in our provider directory regarding every office. Please complete the following information.

Does the office have ADA accessibility, including exam rooms, restrooms and equipment? Yes _____ No _____

Language & Communication Access:

Does the provider speak a language other than English? Yes _____ No _____

If yes, please list language(s): _____

Does the clinic staff speak a language other than English? Yes _____ No _____

If yes, please list language(s): _____

Cultural Competency Training:

Have you completed? Yes _____ No _____ **If yes**, please list year completed: _____

For information on HHS Cultural Competency Program for Oral Health Professionals

<https://oralhealth.thinkculturalhealth.hhs.gov/default.asp>

For Information and Technical Assistance on the Americans with Disabilities Act, go to ADA.gov

https://www.ada.gov/2010_regs.htm

Completed By: _____ Date: _____