

PROVIDER SUPPLEMENTAL FORM

Provider Full Name: _____

Clinic Name/DBA: _____

TIN: _____ Org/Billing NPI: _____

Office Address: _____

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

Office Phone: _____ Office Fax: _____

Contact E-mail: _____

Web Address: _____

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 as a condition of payment consideration. Are you requesting to participate in community outreach from this location?

Yes ___ No ___ **If yes**, please explain: _____

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

Are you accepting **new patients**? Yes ___ No ___ **If yes**, 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.

Are you credentialing/re-credentialing to practice at more than one location? Yes _____ No _____

If yes, please complete a separate form for additional locations.

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: _____

PDMP registration:

Are you registered for the Prescription Drug Monitoring Program (PDMP)

Yes ___ No ___

For information on PDMP registration

<https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/PDMP/pages/index.aspx>

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: _____

This form is for:

Provider Name: _____
Last First Middle

Provider Race, Ethnicity and Language Form

The following information is optional and may be used in provider directories. The organization does not discriminate or base credentialing decisions on an applicant's race, ethnicity, or language. Providing this information is voluntary and will not affect the evaluation of your application.

Race (select all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Prefer not to disclose | <input type="checkbox"/> Alaskan Native |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> American Indian |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Eurasian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Indian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Middle Eastern |
| <input type="checkbox"/> Latino | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> White | |

Ethnicity (select all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Prefer not to disclose | <input type="checkbox"/> Alaskan Native |
| <input type="checkbox"/> African/African American | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Filipino |
| <input type="checkbox"/> English | <input type="checkbox"/> Mexican |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Mongolian | <input type="checkbox"/> Puerto Rican |
| <input type="checkbox"/> Pakistani | <input type="checkbox"/> Taiwanese |
| <input type="checkbox"/> Samoan | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Vietnamese | |

Language(s) (select all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Prefer not to disclose | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> French | <input type="checkbox"/> Persian |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Spanish | |