Capitol Dental

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: _____