# DENTAL PROVIDER PARTICIPATION FORM

**INSTRUCTIONS:** Form to be completed by dental provider and faxed to Anchorage Project Access (APA) at (907) 646-0542.

NAME OF PROVIDER:______________________________________________

PRACTICE/OFFICE NAME: ______________________________________________

SCOPE OF DENTAL PRACTICE OR SPECIALTY: ______________________________________________

ADDRESS:______________________ CITY:__________ STATE: _____ ZIP: ______

PHONE: __________ FAX: __________ EMAIL: ______________________

CONTACT PERSON'S NAME: ______________________ TITLE: ______________________

CONTACT PHONE: __________ FAX: __________ EMAIL: ______________________

**YES**, I will help APA Dental Partnership provide this valuable service to qualified patients.

• Prior to you seeing a patient, each patient receives an initial exam and treatment plan which has been broken down in phases by urgency. APA will send you an **Appointment Request** asking that you complete a phase of treatment. A phase will never consist of more than four or five total procedures in the categories you checked below unless mutually agreed upon. Sample of a phase can include two routine extractions and multiple fillings on two teeth.

I can provide ___ (number of) phases per month. I understand each phase is with a different patient.

Please check what service you would be willing to perform in a phase.

__ Acrylic Anterior Only Partials __ Anterior Root Canals __ Routine Extractions (including exposed root tips)
__ Restorative Fillings __Surgical Extractions __Dental Hygiene

• Some patients present to APA with an emergency (no treatment plan completed) and we would request you provide services for the urgent matter at hand only.

I can provide ___ (number of) emergency services per month.

•Because your office was thoughtful enough to sign up multiple providers, would the office be willing to see more than one APA patient at a given time? Yes __ No__

Appointments will be scheduled by APA staff. Please check below your scheduling preference to see patient at your office.

___ Call office to schedule appointment any time ___ Prefer the time slot(s) listed below:

___ Beginning of day ___ End of day / Mon ____ Tues ____ Wed ___ Thu ___ Fri ____ Sat____

I understand that the treatment I provide is free of charge to the patient, and **always** based on my best clinical judgement. The provided treatment plan and treatment request is a guideline provided by APADP.

______________________ ______________________ __________
Print Provider Name Provider Signature Date

Internal Use Only
__ Licensed Verified #____________
__ Cares-Provider
__ Cares- Group
__ Added Provider List
__Ltr Sent
__Scanned

2401 East 42nd Ave Ste 104 ● Anchorage, AK 99508
Phone: (907) 743-6600 ● Fax: (907) 646-0542
AnchorageProjectAccess.org