



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: _____

HOW DID YOU HEAR ABOUT US: TV Radio Provider Patient Meeting, please list _____
 Other _____

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 separated into phases by levels of urgency 1-5, with level 1 being the highest 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 Partial Anterior Root Canals Routine Extractions (including exposed root tips)
 __ Restorative Fillings Surgical Extractions Dental Hygiene Sedation Nitrous Oral IV

- 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 __

- Languages spoken in office? _____ Do you have interpreter services? Yes No

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

 Provider's Signature

 Date

Internal Use Only:
 __ Licensed Verified # _____
 __ Cares-Provider
 __ Cares-Group
 __ Added Provider List
 __ Ltr Sent
 __ Scanned

3401 East 42nd Ave Ste 104 • Anchorage, AK 99508
 Phone: (907) 743-6600 • Fax: (907) 646-0542 • AnchorageProjectAccess.org