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 Partials __ 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

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