DENTAL PROVIDER PARTICIPATION FORM

INSTRUCTIONS: Form to be completed by dental provider and faxed to (907) 646-0542 or emailed to Provider@AnchorageProjectAccess.org

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 # _____
☐ TrackVia - Location
☐ TrackVia - Provider
☐ TrackVia - Pledges
☐ Letter Sent
☐ Scanned

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