PROVIDER PARTICIPATION FORM

APA DENTAL PARTNERSHIP (APADP)

Through the APA Dental Partnership, local dentists and labs donate their time and skills to serve individuals with urgent dental needs who cannot afford the services. Those receiving help through the APA Dental Partnership also give of themselves by completing hours of volunteer community service.

INSTRUCTIONS: Please complete form and check **ALL** that apply. Fax to APADP 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 in the following way(s).

___ I can provide ____ (number of) Emergency referral(s) per month

___ I can provide ____ (number of) Restorative Filling(s) and/or Build-up(s) per month

___ I can provide ____ (number of) Routine Extraction(s) (including exposed root tips) per month

___ I can provide ____ (number of) Surgical Extraction(s) per month

___ I can provide ____ (number of) Acrylic Anterior Only Partial(s) per month Note: Lab bill will be donated

___ I can provide ____ (number of) Anterior Root Canal(s) per month Note: Only restorable with a large composite

___ I can provide ____ (number of) Dental Hygiene appointment(s) per month

Appointments will be scheduled by APADP 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____

Special comments:

___ I chose not to participate at this time, but you may contact me later _____ or I am not interested _____

___ I can accept Adult Medicaid referrals from APADP if patient is enrolled in Medicaid

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

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