Dental Provider Information

Name of Practice:_____

Phone #:_____Fax:_____Email:_____

Physical Address:_____

City:_____State:_____ZIP:_____

Website Address: _____

NPI #_____or State Medicaid #:_____

Is practice located in or associated with a hospital, school, or community health Center:☐yes ☐no

If ***yes***: Name of facility:_____

List Providers in Practice:

Last Name_____, First Name_____

Phone # (if different from practice)_____

Address (if different from practice)_____

NPI #_____or State Medicaid #:_____

Provider Affiliation: Private Practice☐
Community Health Center☐
Health Department☐
Other☐_____

Active Status: Yes☐
No☐

Provider Specialty: General Dentist ☐
Pediatric Dentist☐
Oral Surgeon☐
Orthodontist☐
Endodontist☐
Periodontist☐
Number of Dental Hygienists?_____

Accepts New Patients:_____ (Y/N) Can Provide Sedation:_____(Y/N)

Can accommodate Special Needs:_____(Y/N)

Can provide services for children with mobility limitations:_____ (Y/N)

Can provide services for children who may have difficulty communicating or cooperating:_____(Y/N)

****Please copy sheet and use for each practitioner in the group.**

Please fax back to WVCHIP at 304-558-2741 or email to paula.m.atkinson@wv.gov