DELTA DENTAL®

Participating Provider Facility Profile Form

FAX COMPLETED FORM TO: (501) 992-1867

Provider's Name:		
License #:	Individual NPI #:	Medicaid #:
Please apply the following participation status to my record: ☐ Premier ☐ Premier/PPO ☐ Delta Dental Smiles		

A SEPARATE FORM MUST BE SUBMITTED FOR EACH SERVICE OFFICE LOCATION

Tax ID #:	Facility Name:	
Org. NPI #:	Business Name:	
Service Office Location:		
City:	State:	ZIP:

Office Hours:	Language(s) Spoken:
Accepting New Patients: ☐ Yes ☐ No	Age Group Treated: ☐ Ages 0-3 ☐ Ages 3-20 ☐ Ages 20-60 ☐ Ages 60+
Do you have specialized training or experience in treating patients with special needs (e.g., intellectual disabilities, autism, cerebral palsy, dementia, ect.)?	☐ Yes ☐ No

_____ Dentist Signature	_____ \ _____ \ _____ Date of Application
Dentist Name:	Telephone:
Name of Office Contact:	FAX:
Email Address of Office Contact:	

For Delta Dental of Arkansas (DDAR) Use Only

_____ DDAR Signature	_____ \ _____ \ _____ Date	_____ \ _____ \ _____ Effective Date

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