Improving the Oral Health of All

Non-Traditional Medical Fluoride Varnish Provider Enrollment Form

Provider Information

Provider Full Name: ____
Last *First* *M.I.*

Address: ____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Phone: ____________________ Alternate Phone: ____________________

Email ____

ID and License Information

Title: ____________________ NPI: ____________________

Taxonomy: ____________________ Medicaid ID: ____________________

License #: ____________________ TIN: ____________________

Name(s) of Managed Care Organization(s) contracted with: ____________________ ____________________

____________________ ____________________

Business Entity Information (Matching W9 and DOO)

Full Business Name: ____

Physical Address: ____
Street Address *Suite #*

____
City *State* *ZIP Code*

Primary Office Phone: ____________________ Alternate Phone: ____________________

Fax: ____

Can Fax accept PHI?
____Yes ____No

Business/1099 Address: ______________________________

Street Address and Suite #

____

City *State* *ZIP Code*

Primary Office Phone: ______________________ Alternate Phone: ______________________

______________________________ ______________

Provider or Office Manager signature *Date*