

# Dental Practice Questionnaire

INSTRUCTIONS	
Return the completed form to: <a href="mailto:dentalcontracting@carefirst.com">dentalcontracting@carefirst.com</a>	Complete this form, attach the following lists and submit them with your applications for contracting in our provider network(s). Please attach the following: <ul style="list-style-type: none"> <li>■ List of all practice locations</li> <li>■ List of all health care practitioners and their professional specialties</li> </ul>

GENERAL INFORMATION	
Business Name	Business Owner
Specialty	
Tax Identification # (include all #s and hyphens)	NPI #
Is the organization funded by the city, state or federal monies? Yes    No	If yes, please indicate the source of the funding and the purpose for which it is to be used (i.e., patient care, administration, teaching, etc.):

PRIMARY ADDRESS (PHYSICAL OFFICE LOCATION)		
Street Address		Office Telephone #
City	State	Zip Code
Office Email		

REMITTANCE ADDRESS, IF DIFFERENT FROM ABOVE (TO RECEIVE REIMBURSEMENT CHECKS)		
Street Address		Office Telephone #
City	State	Zip Code

AUTHORIZED SIGNATURE		
Name (please print)	Signature	
Title	Telephone #	Date
Contact Name	Contact Phone #	Contact Email Address

If you are not yet contracted with CareFirst or are applying to join a new network, please indicate for which of the following you would like to be considered:

<b>DENTAL:</b>		<b>MEDICAL:</b>
Dental Participating Provider Network	Dental Preferred Provider (PPO) Network	I wish to join a medical provider network and understand my application will be forwarded to the appropriate area for processing
Dental FEP Preferred Provider Network	Dental HMO Provider Network	
Medicare Advantage PPO Network		