New York State Medicaid
Dental Group Provider Information Request Form

1. Lease agreements:

   - Please attach a signed copy of your current lease. The lease must indicate the amount of rent and to whom it is paid.

   - If you do not have a lease, please explain:
     _____
     _____

   - Please list the name and address of the owner of the building to be used by the business. If a corporation owns the building, please list the corporation name and the names of the officers and directors of the corporation:

   _____
   _____
   _____

2. Group member status:

   - Are the members of the group employees? Yes ☐ No ☐
   - Are the members' individual subcontractors or consultants? Yes ☐ No ☐
   - Are there any other dentists at your address that are not members of your group? Please explain.
     _____

3. Is the group operated by a management company? Yes ☐ No ☐

   If yes, please list the name of the company and submit a copy of the management contract with your application: _____

4. If the members of the group are employees, attach W2(s), contracts and/or employment verification between the group and individual members.

   If the members are individual subcontractors or consultants, please submit a copy of the 1099 and current contract.

5. Have any members of the group ever been excluded, terminated or denied enrollment or re-enrollment from Medicaid? Yes ☐ No ☐
   If Yes, please list the member's name(s) and explain:
   _____
   _____

   Do any members have license restrictions, such as probation or a monitoring requirement? Yes ☐ No ☐
   If Yes, please list the member's name(s) and explain:

   _____

6. List all dentists, dental assistants and hygienists that were not included as members of the group:

Name **License # and category**

_____
_____
_____

7. List all group members that provide dental specialties and provide a copy of their certification:

_____
_____

8. Identify any locations not listed on your application where you will provide services:

_____
_____

9. Do you provide services in dental vans or any other mobile vehicle?
Yes ☐ No ☐
If Yes, please list the vehicle type, registration number and Vehicle Identification Number (VIN) for each:

Vehicle Type **Registration #** **VIN**

_____
_____
_____

Please note that dental van services will not be reimbursed if you leave this area blank. If you do not currently use a van but add a dental van in the future, a new application must be submitted.

10. Place of service

- Do you provide services in skilled nursing facilities or group homes?
  Yes ☐ No ☐
  If Yes, please list and include any contracts you have with them.
  _____
  _____

- Do you provide services in patients' homes? Yes ☐ No ☐
  If Yes, indicate what percentage of your business is provided in this manner, and describe how you are referred to these patients and by whom.
  _____
  _____

11. Do you provide dental services to children? Yes ☐ No ☐

If yes, do you allow parents in the room where services are provided? _____

Do you use restraints under any circumstances? Yes ☐ No ☐

Please describe _____

12. Does your group utilize a billing service (service bureau)? Yes ☐ No ☐

If so, please provide their name and address. If enrolled in the Medicaid Program, please provide the provider number and a copy of your contract or agreement.

Name **Address** **Provider or NPI #**

_____

_____

If you do not use a billing service, please attach a statement identifying who is authorized to sign the Medicaid claim forms:

_____

_____

13. When did your group start providing services? _____

Please list your total income over the last 12 months: _____

14. Indicate the days and corresponding hours the dental office fill be open

Monday _____ Friday _____
Tuesday _____ Saturday _____
Wednesday _____ Sunday _____
Thursday _____

15. Please list all third party insurers that you currently contract with:

_____

_____

If you do not currently contract with any insurers, please list the insurers that you have submitted bills to within the last 12 months:

_____

_____

16. Estimate the percentage of your total business that will be billed to the Medicaid Program: _____%

17. Has your group recently purchased or acquired an enrolled group in the Medicaid Program? Yes ☐ No ☐

If yes, please name the purchased group and submit a copy of all sales documents.

18. Has your group ever gone under a different name? Yes ☐ No ☐

If yes, please list the name and if ever enrolled, the Medicaid Provider #:

_____

19. List any dental laboratories that your practice utilizes.

_____

If dental laboratory services are performed in-house, please supply purchasing invoices for all equipment and photos of your dental lab area, including equipment.

20. Do you routinely receive referral work from other dentists or groups?
Yes ☐ No ☐

If so, please name:
_____

21. Do you routinely refer work to other dentists or groups?
Yes ☐ No ☐

If so, please name:
_____

Form completed by: _____

Owner's Signature: _____

(form must be signed by an owner of the group)