# APPENDIX B

**OPEN & CONTINUOUS RFP DENTAL SERVICE APPLICATION**

**DDDS Dental Services Open and Continuous Service Provider Request**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| |  |  |  |  | | --- | --- | --- | --- | | Provider Name: |  | Tax ID # |  | |

1. Business Type

Sole Proprietorship  Corporation Partnership

Owners

|  |  |
| --- | --- |
| 1. |  |
| 2. |  |
| 3. |  |

1. Dental Office Address/Hours of Operation

Site Number One Address

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| *Street Address* | | | |
| *City* | *State* | *Zip* | *Phone* |

Hours of Operation

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday | |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Open | Close | Open | Close | Open | Close | Open | Close | Open | Close | Open | Close |

Site Number Two Address (if applicable)

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| *Street Address* | | | |
| *City* | *State* | *Zip* | *Phone* |

Hours of Operation

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday | |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Open | Close | Open | Close | Open | Close | Open | Close | Open | Close | Open | Close |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Year Practice Opened: | |  | | | |  | Medicaid Provider ID#: | |  | | | |
| Check if in process of applying | | |  | | Date application submitted to DMAP: | | | | |  | |
|  |  | | |  | | | |  | | |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Staff Responsible for Billing | | | Name | Email Address | Phone |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Staff Responsible for submitting/  Obtaining treatment plans | | | Name | Email Address | Phone |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Staff Responsible for obtaining prior authorizations | | | Name | Email Address | Phone |

Is your practice prepared to obtain approved treatment plans from DDDS prior to rendering services?

Yes |  No

Is your practice competent with submitting invoices to DDDS within (30) days after service is rendered?

Yes |  No

Are staff adequately trained to acquire proper consent for services is obtained for any services before dental services are rendered?

Yes |  No

Does provider acknowledge DDDS reimbursement for services provided will not exceed the published Medicaid Dental Fee Schedule in place on date of service?

Yes |  No

Describe process for handling emergent after hour service delivery:

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| --- |
|  |
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|  |

Does your office use conscientious sedation?

Yes |  No

If yes, describe your training/policies in place to ensure safety during and after the procedure. Explain how you return the patient to baseline before discharge:

|  |
| --- |
|  |
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|  |

Does your office use anesthesia and/or deep sedation?

Yes |  No

If yes, describe your training/policies in place to ensure safety during and after the procedure. Explain how you return the patient to baseline before discharge:

|  |
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|  |

*CONTRACTORS must check “yes” or “no” to the following questions. Answers to these questions are mandatory and do not affect the weighted evaluation of this proposal.*

Does the CONTRACTOR have a Supplier Diversity plan currently in place?

Yes |  No

Does the CONTRACTOR have any diverse sub-CONTRACTORS as outlined in Attachment 8 Tier II Sub-CONTRACTORS?

Yes |  No

Does the CONTRACTOR have a written inclusion policy in place? If yes, attach a clearly identified copy of the inclusion plan to your proposal.

Yes |  No

|  |
| --- |
|  |

Attestation Statement By my signature below, I am attesting I am an authorized representative of the entity named and I acknowledge the information provided on this form is true and accurate.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Signature | | Date | |
|  |  |  |  |
| Title |  |  |  |

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