

## DENCAP Dental Plans - Office Information

\* Denotes required field.

### Practice Information

\*Office Name (from W9 - no abbreviations):

Office DBA Name (if different - no abbreviations):

\*Address (Street & City):

\*State:

\*Zip:

\*Office Email Address:

\*Phone:

\*Fax:

Office Email Contact:

\*Tax ID:

\*Type II NPI:

\*Practice Type (select one):

Solo
  Group
  Specialty Group
  PA161
  Mobile
  County/FQHC
  IHC

### Remittance (Payments) Address *(if different from above)*

Contact:

Phone:

Fax:

Address (Street & City):

State:

Zip:

### Credentialing Contact

Name:

Phone:

Fax:

Email:

### Office Manager

Name:

Phone:

Fax:

Email:

### Office Hours *Please enter NA in the Open/Close fields when the office does not have hours that day.*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
*Open:	*Open:	*Open:	*Open:	*Open:	*Open:	*Open:
*Close:	*Close:	*Close:	*Close:	*Close:	*Close:	*Close:

\*24/7 Phone Coverage:  Yes  No

If Yes, please select any that apply:

Answering Service  Voice Mail With Instructions To Call

Other (explain): \_\_\_\_\_

\*After Hours Phone:

Website:

\* Denotes required field.

**Languages Spoken in Office**

List languages spoken other than English:

**ADA Information: Please indicate Which, If any, of the Following ADA Accommodation/ Accessibility Standards Your Office Meets.**

- Yes  No \*Meets Standards for the physically disabled.
- Yes  No \*Medical Equipment: Meets Accessibility Standards for Handicap Accessible Medical Equipment.
- Yes  No \*Meets Accommodation Standards for the intellectually and/or Cognitively Disabled
- Yes  No \*Meets Accommodation Standards for the Blind/Visually Impaired.
- Yes  No \*Meets Accommodation Standards for the Deaf or Hard-of-Hearing.

**Providers at this location (attach roster if needed)**

**See Attached Roster**

Name:	License:
Name:	License:
Name:	License:
Name:	License:
Name:	License:
Name:	License:

**Submit Via:**

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