

## 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): <input type="checkbox"/> Solo <input type="checkbox"/> Group <input type="checkbox"/> Specialty Group <input type="checkbox"/> PA161 <input type="checkbox"/> Mobile <input type="checkbox"/> County/FQHC <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please select any that apply: <input type="checkbox"/> Answering Service <input type="checkbox"/> Voice Mail With Instructions To Call <input type="checkbox"/> 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:**

**DENCAP Dental Plans | 45 E Milwaukee St., Detroit, MI 48202**

**P: 313.972.1400 | F: 313.922.5790 | Email: providers@dencap.com**