LIBERTY DENTAL PLAN

OH Medicaid Provider Participation Information Sheet

*Required Fields

Please complete one Information Sheet per Provider.

PROVIDER INFORMATION:

***Provider Name:** _____ ☐ DDS ☐ DMD ☐ Other (specify): _____

***Date of Birth:** ____/____/_____ **Gender:** ☐ Male ☐ Female

Race: **Ethnicity:**

***Social Security #:** _____

***License #/Exp Date** _____

***DEA #/Exp Date** _____

***NPI Type 1** (Individual): _____

***State Medicaid Rendering #:** _____ **State Medicaid Billing #:** _____

EDUCATION INFORMATION:

***Specialty Type:**
☐ General Dentist ☐ Endodontist ☐ Pediatric Dentist ☐ Periodontist
☐ Oral Surgeon ☐ Orthodontist ☐ Prosthodontist ☐ Other: ____

***Do you have Hospital Privileges?** ☐ YES ☐ NO (Please Check "NO" if not applicable. Do not leave blank.)

Hospital Name(s):

*Do you have current and valid state issued permits to administer Oral, Enteral, Parenteral, Intravenous, Inhalation, Conscious and/or Pediatric Conscious Sedation? ☐ YES ☐ NO

IF YES, please check all permits that you maintain and that apply to your licensure in the state you are applying for:

☐ Oral/Enteral Sedation ☐ Parenteral Sedation ☐ Intravenous Sedation ☐ Inhalation Sedation ☐ Moderate Sedation
☐ General Anesthesia ☐ Conscious Sedation ☐ Pediatric Conscious Sedation

Languages Spoken: _____

LOCATION INFORMATION:

1.***Office Name:**_____***NPI type** 2:_____***Office Medicaid #:**_____

Address: _____

For additional locations complete below:

2.***Office Name:**_____***NPI type** 2:_____***Office Medicaid #:**_____

Address: _____

3.***Office Name:**_____***NPI type** 2:_____***Office Medicaid #:**_____

Address: _____

Submit