



# Non-Traditional Medical Fluoride Varnish Provider Contact Enrollment Form

## Provider Information

Provider Full  
Name:

\_\_\_\_\_  
*Last* *First* *M.I.*

Address:

\_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_  
*City* *State* *ZIP Code*

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Email \_\_\_\_\_

## Unique Provider ID and License Information

Title: \_\_\_\_\_ NPI: \_\_\_\_\_

Taxonomy: \_\_\_\_\_ Medicaid ID: \_\_\_\_\_

License #: \_\_\_\_\_ TIN: \_\_\_\_\_

Name(s) of  
Managed Care  
Organization(s)  
contracted with:  
\_\_\_\_\_  
\_\_\_\_\_

## Business Entity Information (Matching W9 and DOO)

Full Business  
Name: \_\_\_\_\_

Physical Address: \_\_\_\_\_  
*Street Address* *Suite #*

\_\_\_\_\_  
*City* *State* *ZIP Code*

Primary Office Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Can Fax accept PHI?  
 Yes  No

Business NPI:  
\_\_\_\_\_  
\_\_\_\_\_

Business Medicaid ID:

\_\_\_\_\_

Business/1099 Address:

\_\_\_\_\_  
*Street Address and Suite #*

\_\_\_\_\_  
*City*

\_\_\_\_\_  
*State*

\_\_\_\_\_  
*ZIP Code*

Primary Office  
Phone:

\_\_\_\_\_

Alternate Phone:

\_\_\_\_\_

\_\_\_\_\_  
*Provider or Office Manager signature*

\_\_\_\_\_  
*Date*