LIBERTY DENTAL PLAN ®

FACILITY APPLICATION *(Complete one application per facility)*

Facility Information

PRACTICE NAME (DBA): _____

PRACTICE ADDRESS: _____

Street Address   *Suite/Unit #*

City   *State*   *Zip*   *County*

TELEPHONE #: ( ) _____   **Fax #:** ( ) _____

EMERGENCY #: _____   **EMAIL ADDRESS:** _____

INDIVIDUAL NPI #: _____   **ORGANIZATIONAL NPI #:** _____
(if applicable)

TAX PAYOR IDENTIFICATION (TIN): _____   **CONTACT NAME:** _____

ALTERNATE MAILING ADDRESS: *(if different from practice address)*

☐ PAYMENT REMITTANCE   ☐ CORRESPONDENCE

Street Address   *Suite/Unit #*

City   *State*   *ZIP Code*

LANGUAGES SPOKEN: _____

RECALL METHOD USED: _____

PRIMARY DENTIST:	_____	☐ DDS	☐ DMD	☐ Other	_____
ASSOCIATE DENTIST:	_____	☐ DDS	☐ DMD	☐ Other	_____
ASSOCIATE DENTIST:	_____	☐ DDS	☐ DMD	☐ Other	_____
ASSOCIATE DENTIST:	_____	☐ DDS	☐ DMD	☐ Other	_____

Please check if this facility is designated as any one of the following:

☐ **(FQHC)** Federally Qualified Health Center   ☐ **(CHC)** Community Health Center   ☐ **(IHS)** Indian Health Services   ☐ **(RHC)** Rural Health Clinic

Accessibility

Does this facility have a 24 hour emergency contact system? ☐ Yes   ☐ No   **Special Needs** ☐ Yes   ☐ No

What type of emergency contact system is used? _____

Is this facility wheelchair accessible? ☐ Yes   ☐ No

Age range of patients seen? ☐ All Ages   ☐ 0 – 21

Minimum Treatment Age: _____   ☐ Other: _____

Hours of Operation

Day		AM		PM
Monday		AM		PM
Tuesday		AM		PM
Wednesday		AM		PM
Thursday		AM		PM
Friday		AM		PM
Saturday		AM		PM
Sunday		AM		PM

Appointment Wait Times

Initial _____ **days**

Hygiene _____ **days**

Routine _____ **days**

Lobby Wait Time _____ **minutes**