Wyoming Department of Health

# Dental Provider Member Acceptance Form

**Provider Name** _____ **NPI/ Provider Number** _____

**Provider Address** _____
Street Address City State Zip Code

**Provider Office Contact Person** _____ **Contact Number** _____

| Yes | No | | |
|---|---|---|---|
| ☐ | ☐ | 1. | Are you currently seeing Medicaid members? |
| ☐ | ☐ | 2. | Are you currently accepting new Medicaid members? |
| ☐ | ☐ | 3. | Are you currently seeing/accepting children with special health care needs? |
| ☐ | ☐ | 4. | Are you currently seeing/accepting adults with special health care needs? |
| ☐ | ☐ | 5. | Can your office provide services for children with mobility limitations? |
| ☐ | ☐ | 6. | Can your office provide sedation for children with complex medical or behavioral conditions? |
| ☐ | ☐ | 7. | Can your office provide services for children who may have difficulty communicating or cooperating such as those physical or intellectual disabilities? |

**Dentist Signature** _____ **Date** _____
mm/dd/yyyy

A Provider's form must be received by the Division of Healthcare Financing by July 15th of each year.
Each Provider is responsible for completing a new form if their policy on accepting Medicaid clients changes during the year.

**Mail completed form to:**
Division of Healthcare Financing, Medicaid
Attn: Dental Program Manager
122 W. 25th Street, 4th Floor West
Cheyenne, WY 82002
OR
Submit this form by Fax to (307) 777-7085