SITE APPLICATION ***(Complete one application per site)***

Site Information

Please check below the site type this application applies to:

SITE TYPE *(Please select one)* **Hospital** ☐ **Mobile Unit** ☐ **School Based** ☐ **Skilled Nursing** ☐ **Surgical Center** ☐

SITE NAME: _____

SITE ADDRESS: _____
Street Address *Suite/Unit #*

_____
City *State* *Zip* *County*

MAILING ADDRESS:

☐ PAYMENT REMITTANCE ☐ CORRESPONDENCE

_____
Street Address *Suite/Unit #*

_____
City *State* *ZIP Code*

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

EMERGENCY #: _____

EMAIL ADDRESS: _____

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

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

LANGUAGES SPOKEN: _____

DENTIST		**LICENSE**		**SPECIALTY**	
DENTIST		**LICENSE**		**SPECIALTY**	
DENTIST		**LICENSE**		**SPECIALTY**	
DENTIST		**LICENSE**		**SPECIALTY**	
DENTIST		**LICENSE**		**SPECIALTY**	