



MHCP Critical Access Dental Practice Designation Request

For the period January 1, 2008 - December 31, 2008
SUBMISSION DEADLINE: 4:00 p.m., Friday, December 14, 2007

Read instructions on next page before you start. Practices with multiple locations must submit one application for each location. Type or neatly print all information in black or blue ink. MHCP will not consider incomplete, incorrectly completed or late requests.

A. PRACTICE INFORMATION

1. PRACTICE NAME		FEDERAL EMPLOYER ID # (FEIN)	PRACTICE NPI #	
PRACTICE LOCATION STREET ADDRESS		CITY	STATE	ZIP CODE
CLINIC PHONE ()		CONTACT PERSON	CONTACT PHONE ()	FAX ()
MAILING ADDRESS (IF DIFFERENT THAN PRACTICE ADDRESS)		CITY	STATE	ZIP CODE

2. NAME(S) OF DENTISTS AND COLLABORATIVE PRACTICE DENTAL HYGIENISTS (SEE MINNESOTA STATUTE 150A.10) IN THIS PRACTICE (attach separate sheet if additional space is needed)	INDIVIDUAL PROVIDER NPI #

B. CRITICAL ACCESS DENTAL PARTICIPATION STATUS

3. MANAGED CARE CONTRACTS	
<input type="checkbox"/> Blue Plus <input type="checkbox"/> First Plan Blue <input type="checkbox"/> HealthPartners <input type="checkbox"/> Itasca Medical Care <input type="checkbox"/> Medica <input type="checkbox"/> Metropolitan Health Plan <input type="checkbox"/> PrimeWest Health Plan <input type="checkbox"/> South Country Health Alliance <input type="checkbox"/> UCare Minnesota	
4. PRACTICE TYPE(S) <input type="checkbox"/> General <input type="checkbox"/> Specialty - List type(s) _____	
5. TOTAL UNDUPLICATED NUMBER OF PATIENTS SERVED BY PRACTICE 1/1/06 - 12/31/06	6. 2006 TOTAL GROSS RECEIPTS FOR HEALTH CARE SERVICES (Line 1 from the practice's 2006 MinnesotaCare Worksheet C - Annual Tax Return*)
7. CRITERIA FOR DESIGNATION	
<input type="checkbox"/> Twenty percent or more of the practice's patient base must be MHCP recipients. <input type="checkbox"/> This practice intends to meet or exceed a patient base of 20% in the first six months of 2008. Submit an affidavit to DHS by June 1, 2008, indicating that the patient base is at or exceeding 20%. The practice will be eligible for CADPP payments beginning July 1, 2008. <input type="checkbox"/> This is a specialty practice that agrees to increase the number of MHCP patients seen in 2008 to 20% or accept all MHCP patients seeking care until the 20% level is reached. Eligible specialty practices include: Endodontics, Oral Surgery, Orthodontics, Pedodontics, and Periodontics. <input type="checkbox"/> This practice does not meet the above criteria but is located in one of the following counties: Cook, Lake of the Woods, Mahanomen, Marshall, Pennington, Polk, Pope, or Red Lake. This practice agrees to increase the number of MHCP patients seen in 2008 to 20% or accept all MHCP patients seeking care until the 20% level has been reached.	

C. CERTIFICATION - I (We) certify that all information presented in this request is true and correct to the best of my (our) knowledge.

PRACTICE OWNER SIGNATURE	DATE
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* A copy of the practice's 2006 MinnesotaCare Worksheet C - Annual Tax Return must be included.

Instructions for Completing MHCP Critical Access Dental Practice Designation Request

MHCP will not consider incomplete, incorrectly completed or late requests.

To become a CADPP provider, a practice must be enrolled with MHCP or a contracted managed care organization (MCO). For MHCP enrollment information, view www.dhs.state.mn.us/provider/enrollment.

IMPORTANT:

- Submit one Designation Request form for all providers whose taxes are filed under the same Federal Employer Identification Number (FEIN).
 - For practices with more than one location, submit a separate form for each location
 - Each separate location must have a unique NPI
 - Practices with more than one FEIN must submit one application for each FEIN

A. PRACTICE INFORMATION

1. Name of Practice

Enter the full legal name of the practice.

Federal Employer I.D.

Enter the FEIN for which this request is made. All information entered in the following boxes must apply to only this FEIN. Practices with more than one FEIN must submit one application for each FEIN.

Practice NPI

Enter the 10-digit NPI Number. **Important: Enter the billing provider or entity's number, NOT the treating provider number.** If this practice is designated as critical access, DHS will pay enhanced payments only to FFS claims submitted under this number.

Practice Location Address

Enter the physical location address of the practice. If you have more than one practice location, submit a separate Designation Request for each location.

City, State, Zip Code

Enter the city, state and zip code.

County

Enter the county where the address in Box (A) is located.

Clinic Phone

Enter the business phone number of the clinic.

Contact Person

Enter the name of a person who can be contacted about this request form.

Contact Phone

Enter phone number at which contact person can be reached.

FAX

Enter the fax number for the contact person.

Mailing Address

Enter only if different than the practice location address.

City, State, Zip Code

Enter the city, state and zip code.

2. Names of Dentists and Collaborative Practice Dental Hygienists

Enter the full legal names of all dentists and collaborative practice dental hygienists who were in this practice between January 1, 2006, and December 31, 2006. If any of the dentists are no longer included under this FEIN, or if currently additional dentists or collaborative practice dental hygienists are included, please attach a note identifying these providers.

Individual Provider NPI

Enter the corresponding 10-digit NPI number for each dentist listed. Enter the corresponding 10-digit NPI number for each collaborative practice dental hygienist listed, if enrolled as an MHCP provider. (Collaborative practice dental hygienists are not required to have individual MHCP provider numbers at this time.) Use a separate sheet if you need more space.

B. CRITICAL ACCESS DENTAL PARTICIPATION STATUS

3. Contracts

Check each managed care plan with which this practice has a contract to serve MHCP recipients.

4. Practice Type(s)

Check the appropriate box. If this practice provides specialty care, indicate type(s) of specialty(ies). List only specialty types recognized by the American Dental Association.

5. Total Patients Served

Enter the total number of patients (unduplicated) seen between 1/1/06 and 12/31/06 by this practice at the location entered in Box (A). "Patient" is defined as: a person who has received dental care services from a provider of the practice for treatment of a dental condition for whom the practice has received payment; for whom the provider has made a comprehensive set of dental services available; and who has not been dismissed from the practice by the provider. Include all payer types: commercial insurance, cash, MHCP (MA/GAMC/MinnesotaCare), etc.

6. 2006 Total Gross Receipts for Health Care Services

Enter the total gross receipts for health care services in 2006. Use the amount designated in Line 1 of the practice's MinnesotaCare Worksheet C - Annual Tax Return for 2006. A copy of this worksheet must accompany this application.

7. Criteria for Designation

Check the appropriate box and follow any instructions. Do not check more than one box.

C. CERTIFICATION

Sign and date, certifying that the information on the form is true and correct to the best of your knowledge. If practice has multiple owners, all owners must sign and date this Designation Request.

Next Step

Fax completed form, a copy of the practice's 2006 MinnesotaCare Worksheet C - Annual Tax Return and any attachment(s) to the Minnesota Department of Human Services at (651) 431-7462 by 4:00 p.m., Friday, December 14, 2007.