PROVIDER SURVEY

Person providing information: _____

Date: _____

First Name:_____ **Last Name:**_____

Name of Provider or Practice:_____

NPI#:_____ **Federal Tax ID#:**_____

Type of Practice: Group ☐ Solo ☐ Other ☐

Address 1:_____ **Address 2:**_____

City :_____ **State :**_____ **Zip Code :**_____

Phone:_____ **Fax:**_____

Email:_____

Specialty Types: General Practice ☐ Orthodontic ☐ Oral Surgery ☐ Endodontic ☐
Pediatric ☐ Clinic ☐ FQHC ☐ Other ☐

Plans Accepted: HUSKY A ☐ HUSKY B ☐ HUSKY C ☐ HUSKY D ☐

Minimum Age Seen: _____ **Maximum Age Seen:** _____

Languages Spoken in office: **Language 1:**_____ **Language 2:**_____

Language 3 :_____ **Language 4:**_____ **Language 5:**_____

OFFICE HOURS

DAY	FROM	TO
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Please list all Associates in practice:

_____

_____

_____

Do you have other offices serving CTDHP clients? (If so list addresses) _____

_____

Bus Route Number _____
(If the bus route # is unavailable, put Y or N)

QUESTIONAIRE

	YES	NO	MORE INFO
Are you still participating in the CT Medical Assistance Program?			
If so, are you accepting new patients at this time? If you are not accepting new patients now, when would you like to start receiving referrals?			
Is the office wheelchair accessible?			
Will your practice see clients with special health care needs?			
Does your practice provide Nitrous Oxide in the office?			
Does your practice provide IV Sedation in the office?			
Does your practice provide Conscious Sedation in the office?			
Does your practice provide assistance transferring into the dental chair?			
Does your practice help with coordination or movement difficulties?			
Will your practice provide treatment for a patient in a wheelchair who cannot be transferred to a dental chair?			
Will your practice see patients with developmental disabilities or those with mental impairment?			
Will your practice see patients with anxiety disorders or mental health issues?			
Does your office perform Conebeam CT Scans?			
Will your office treat patients at hospital facilities under general anesthesia? If so, what hospital is the dentist affiliated with?			
Will your office see patients with speech or communication difficulties?			
Will your practice see patients with Autism?			
Will your practice see patients with ADD or ADHD?			
Will your practice see patients with Cystic Fibrosis?			
Will your practice see patients who are visually impaired?			
Will your practice see patients with epileptic or seizure disorders?			

	YES	**NO**	**MORE INFO**
Will your office see patients who are hearing impaired?			
Will your practice see patients with Cerebral Palsy?			
Does your office operate or participate in any Mobile Dental program?			
Does your office offer sleep apnea devices?			
Will your office treat pregnant patients? If NO Please ask for feedback as to Why not?			
If the office doesn't treat Pregnant patients don't ask these questions!			
Will your office treat any pregnant patients under the age of 21 years old?			
Will your office treat any pregnant patients over the age of 21 years old?			
To treat does your office need a letter from the patient's OB/GYN or Midwife?			
Do you only need OB/GYN letter in certain circumstances? **Get Details**			
Will your office contact the OB/GYN or Midwife before treatment?			
If the OB/GYN indicates that there are no restrictions in treating the pregnant patient:	**YES**	**NO**	
Will your office provide Preventive services?			
Will your office provide Restorative services?			
Will your office provide Urgent care?			
Will your office provide Emergency care?			
Will your office treat in first trimester?			
Will your office treat in second trimester?			
Will your office treat in third trimester?			
Will your office use local anesthesia?			
Will your office take x-rays if medically necessary with lead apron?			
Are there any other restrictions on your treating a pregnant patient? If **YES** please specify:			