

## ConnectCare/Dental Coordinated Care - Provider Request Form

**Fax:** (501) 280-4180

**Toll-Free Helpline:** 1-800-322-5580

**Email:** connectcare.dental@arkansas.gov

**Dental Provider's Name:** \_\_\_\_\_ **Provider #:** \_\_\_\_\_

**Physical Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Contact(s):** \_\_\_\_\_

<b>Beneficiary's Name:</b>	<b>Date &amp; Time of New Appointment:</b>
<b>Medicaid/ARKids First #:</b>	
<b>Date of Birth:</b>	<b>Date &amp; Time of Missed Appointment:</b>
<b>Responsible Party:</b>	
<input type="checkbox"/> Use address listed in Medicaid system.	<input type="checkbox"/> It's Time to Schedule an Appointment <b>Type of Appointment:</b>
<b>Mailing Address:</b>	
<b>City, State, Zip:</b>	<input type="checkbox"/> We Have Dismissed This Patient <b>Reason for Dismissal:</b>
<b>Telephone Number(s):</b>	
<b>Notes:</b>	<input type="checkbox"/> May Need Transportation Assistance
	<input type="checkbox"/> May Need Spanish Interpretation

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