

**MEDICAID AGREEMENT LETTER**

**DENTIST**

I agree to provide eligible dental services to an average of two (2) Medicaid eligible clients per week. I recognize that this agreement will result in an increase in the Medicaid payment amount of 20% for services rendered on or after July 1, 1997, and that initially these payments will be made on a prospective basis based on my Medicaid payments for the previous quarter.

Payment of the additional 20% will begin for the payment cycle after this signed agreement has been received by the Bureau of Medicaid Operations. Rural providers are not eligible for the additional 20% volume payment, they will receive an automatic 20% because they are providing services in a rural area.

\_\_\_\_\_  
Dentist's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
NPI Number

**ORAL SURGEON**

I agree to have my name included on a referral list for Medicaid clients, and will accept Medicaid referrals. I understand that this agreement will result in a 20% increase on the Medicaid payment schedule for all Medicaid client services. Rural providers are not eligible for the additional 20% referral list payment, they will receive an automatic 20% because they are providing services in a rural area.

\_\_\_\_\_  
Oral Surgeon's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
NPI Number

**Please return signed form to:**

**Medicaid Provider Enrollment  
Box 143106  
Salt Lake City UT 84114-3106**

**Voice line 801-538-6155 or 1-800-662-9651  
Fax line 801-538-6805**

**IF YOU ARE NOT CURRENTLY A MEDICAID PROVIDER AND WISH TO APPLY, PLEASE CALL THE VOICE LINE NUMBER ABOVE.**