KENTUCKY DENTAL CARE PROGRAM
PARTICIPATING DENTIST AGREEMENT

Yes, I will participate in the Kentucky Physicians Care Program by providing services without charge for the first office visit to eligible patients.

CHOOSE ONE: I am a Dentist (DMD/DDS)

I am a Dental Assistant, Hygienist of ________________________________ DMD/DDS

CHOOSE ONE: I agree to see KPC patients as necessary each month.

I agree to see up to (#) ______________ KPC patients per month.

NAME: ____

STATE LICENSE # _________________________________ EXP. DATE ___________________________________

SPECIALTY ____

OFFICE ADDRESS ____

CITY ____ ZIP ___________________________

COUNTY ____ E-MAIL ADDRESS ____________________________

OFFICE PHONE (_____)______________________________ FAX (_____)____________________________________

OFFICE CONTACT: ________________________________ PHONE (OR) EXTENSION ______________________

SIGNATURE ____ DATE ______________________________

Please complete and mail to:

Health Kentucky, Inc.

140 Consumer Lane
Frankfort, Kentucky 40601
(502) 227-3158