



First Dental Home Certification Application

Dentist's Name: _____

Pediatric Dentist

General Dentist

Taxonomy Code: _____ TX Dental License # _____

Private Practice

FQHC

Rural Health Clinic

Individual National Provider Identifier number (**NPI**): _____

Individual Texas Provider Identifier number (**TPI**): _____

Only for FQHC - Group **TPI** (If applicable): _____

Office Contact Person: _____

Email address) _____

(Where you want confirmation sent; *Please print legibly and clearly*)

I am a currently enrolled Texas Health Steps Dental Provider

I have submitted an enrollment application as of _____
(Date of submission)

Primary Location:

Primary Office Address: _____

City: _____ Zip Code: _____

Office Phone # (Area Code + Number): _____

Office Tax ID: _____ Training date: _____

Please fax Certification Request Form AND a copy of your CE certificate to:

Attn: Louise Friedman

Fax: 512-776-7256

Phone: 512-776-2110

Louise.friedman@hhsc.state.tx.us