



Oral Evaluation and Fluoride Varnish in the Medical Home Registration Form

Performing Provider Name: _____

Private Practice **Group Practice** **FQHC** **Rural Health Center**

Name of Group/Facility _____

Primary care Physician Physician Assistant Advanced Practice Nurse

Taxonomy code: _____ Group Tax ID _____

Please provide the following REQUIRED information:

Individual NPI (National Provider Identifier number): _____

Group NPI (National Provider Identifier number): _____

Do you have a PERSONAL THSteps TPI number (Texas Provider Identifier number)?

- Yes**
- No**

If yes, what is your **PERSONAL THSteps TPI** number _____

Group THSteps TPI (Number used to bill Medicaid) _____

I am a currently enrolled Texas Health Steps Primary Care Provider

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

Physical Address (Street, Suite): _____

City: _____ Zip Code: _____

Phone Number (Area Code + Number): _____

Office Contact: _____

(Someone who can answer questions)

Email address: _____

(where you want verification sent **(Please print legibly and clearly)**)

Date Training Completed: _____

Please fax completed Certification Request Form ALONG with your CE certificate to:

Fax: **512-458-7256** Attention: Louise Friedman

or email to louise.friedman@hsc.state.tx.us

Phone: 512-776-2110