## <u>Connecticut Oral Health Assessment and Fluoride Varnish Application</u> <u>Training Record Sheet</u>

For medical providers to bill HUSKY Health for oral health assessments and fluoride varnish applications, you must be trained and submit this form along with your CME certificate.

<u>Please print clearly</u>. The trained principal provider in the office should be entered on this page. Additional trained providers at the same location can be listed on page two.

Principal Trained Provider:		
	(Full Name)	(MD, DO, APRN, PA)
Office Name:		
Office Address:		
	(Street Address line 1)	
	(Street Address line 2)	
City, State, Zip:		
Principal Trained Provider NPI #:		
Email Address:		
Telephone:		
Signature & Date:(Signatu	ire)	(Date)
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When complete, please send along wi	th CME certificates to the Conr	ecticut Dental Health Partnership:
Fax: 860-674-8174	email: <u>communitypart</u>	ners@ctdhp.com

## Additional Trained Providers at Same Location

(Don't forget to send a CME certificate for each)

(Trained Provider Full Name)	(MD, DO, APRN, PA)	(NPI#)
 (Signature & I		
(Signature & I	Jatej	
(Trained Provider Full Name)	(MD, DO, APRN, PA)	(NPI#)
 (Signature & I	Date	
	Jacej	
(Trained Provider Full Name)	(MD, DO, APRN, PA)	(NPI#)
 (Circolando)		
(Signature & I	Jatej	
(Trained Provider Full Name)	(MD, DO, APRN, PA)	(NPI#)
(Signature & I	Date)	
(Trained Provider Full Name)	(MD, DO, APRN, PA)	(NPI#)
(Signature & I	Date)	