**FORM A: OPEN ENROLLMENT APPLICATION**

**Texas Department of State Health Services**

**Newborn Screening Program Benefits Program**

**Open Enrollment Application, Enrollment HHS0014639**

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| **APPLICANT INFORMATION** |
| Legal Business Name: |
| **PROVIDER TYPE** (Please check the appropriate box and include the corresponding form) |
| [ ] Entity **FORM B-1**[ ] Laboratory Provider **FORM B-2**[ ] Pharmacy Provider **FORM B-3**[ ] Low Protein Foods Provider **FORM B-4** |

*Please list all locations where Newborn Screening Program Benefits Program Services will be provided*. ***Add additional pages as needed.***

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| Name of Entity (such as facility or clinic)/Laboratory/Pharmacy/ Low Protein Foods Provider(s): |
| Street Address:  |  |
| City/State/Zip Code: |  |
| Phone Number: |  |
| Fax Number: |  |
| Appointments Phone Number: *(If different from above)* |  |
| Days of Operation:*(Check all that apply)* | [ ]  Monday [ ]  Tuesday [ ]  Wednesday [ ]  Thursday [ ]  Friday [ ]  Saturday [ ]  Sunday |
| Hours of Operation: |  |
| Other Information: |

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| Name of Entity (such as facility or clinic)/Laboratory/Pharmacy/Low Protein Foods Providers: |
| Street Address:  |  |
| City/State/Zip Code: |  |
| Phone Number: |  |
| Fax Number: |  |
| Appointments Phone Number: *(If different from above)* |  |
| Days of Operation:*(Check all that apply)* | [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Sunday |
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| Name of Entity (such as facility or clinic)/Laboratory/Pharmacy/Low Protein Foods Providers: |
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| Other Information: |