**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: |  |
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| Other Information: | |