BUCKNER®
Hope shines here.®

Medical Provider Form

Family Name: _____ Date: _____

Please fill out for your Primary Care Physician and Dentist you will plan to use for foster/adoptive children.

Primary Care Physicians

Name: _____

Specialty: _____

Street Addres: _____

City/Zip: _____

Phone: _____ Fax: _____

Dentists

Name: _____

Specialty: _____

Street Addres: _____

City/Zip: _____

Phone: _____ Fax: _____

We/I understand that we must use a physician/dentist that accepts the Star Health Medicaid Program for foster children and follows Texas Health Steps. If at the time of placement these physicians/dentists are not accepting the Star Health Medicaid Program or new patients, we/I will seek assistance for other options from our Buckner Case Manager.