DELTA DENTAL

CHANGE OF ADDRESS FORM

Tax Identification Number: _____

Facility / Business Name: _____

Effective ___/___/___ the address below will change.

Change Applies To:

_____ Service Office Address _____ Payment / Mailing Address _____ Both

Old Address: _____

City: _____ Zip: _____

Phone: _____ Fax: _____

New Service Office Address: _____

City: _____ Zip: _____

Phone: _____ Fax: _____

New Mailing Address: _____
(If Applicable)

City: _____ Zip: _____

Office Hours: ☐ Standard Business Hours (8am – 5pm) ☐ Early Morning Hours (before 8am)
☐ Evening Hours (after 5) ☐ Weekend Hours (Saturday)

Secondary Language: _____

Please circle one:
Accepting New Patients? YES/NO
Public Transportation Available? YES/NO
Services Mobility? YES/NO
Handicap Accessible? YES/NO
Treats Disabled Adults? YES/NO
Treats Disabled Children? YES/NO

Please list ALL providers associated with Tax ID Change. Attach additional sheets if necessary. Please indicate participation for each dentist and if the location will be a primary location or a fill in location.

			Participation:	***Location type:***
_____	Lic. # _____	NPI _____	Premier ☐ Premier/PPO ☐	Primary ☐ Fill In ☐
_____	Lic. # _____	NPI _____	Premier ☐ Premier/PPO ☐	Primary ☐ Fill In ☐
_____	Lic. # _____	NPI _____	Premier ☐ Premier/PPO ☐	Primary ☐ Fill In ☐

Name of Person Completing Form: _____ Date: ____/____/____

Please Note:
Your record will be updated accordingly upon receipt of this form along with a completed W-9. Dentist who are indicated as fill in dentist for this location will not be listed on our Dentist Directory. This will not affect participation in our network. Submitting claims with this information prior to confirmation of update may result in payments made directly to our members.

Delta Dental of Arkansas
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