

Provider Information Change Form

Contact Information & Instructions - For questions please call: 800-999-9789

Please fax, mail or email completed forms to:

Dental Select Provider Relations
75 W Towne Ridge Parkway
Tower 2, Suite 500
Sandy, UT 84070
Fax: 801-290-5108 or 888-998-8708
provider@dentalselect.com

IMPORTANT:

- Only submit this form if your information has changed or will change.
- Changes may include closing a location, moving a location, or transferring a contract.
- Please notify Dental Select of any changes within 15 days.

Current Information (Required)

Dentist Name (as submitted on claims)

Provider TIN (If TIN is new, see next section)

NPI Number, Type 1 (Provider)

Changed Information**Provider Information** - Check boxes to indicate any changes**Effective Date of Change (Required)**
 Dentist Name (as submitted on claims)

 DDS

 DMD

 Specialty: _____

 Provider TIN

 If TIN is new, please include a new W-9 form, available at www.dentalselect.com

 Are you moving from a location? Y N

 If Yes, What location?
Would you like your in-network contract to move over? Y NDo you want to be contacted about joining the Dental Select Provider Network? Y N**Billing Information** - Check boxes to indicate any changes**Effective Date of Change (Required)** Billing Name (as submitted on claims) Billing Address (as submitted on claims) Billing City / State / Zip Code Billing Phone Billing Fax Billing Email**Practice Location Information** - Check boxes to indicate any changes
Effective Date of Change (Required)

 Same As Billing Information Above
 Practice Name Practice Address Practice City / State / Zip Code Practice Phone Practice Fax Practice Email

Notes

Authorization of Change - (Required for all requested changes)

Provider Signature

Date Signed (MM/DD/YYYY)

 Mail: Dental Select (Attn: Eligibility) 75 W Towne Ridge Parkway, Tower 2 Suite 500, Sandy Utah 84070
 Fax: (801) 290-5101 Toll Free Fax: (888) 998-8704