DELTA DENTAL®

# Additional Office Information Sheet

This form is to be used for adding a location with the same Tax Identification Number (TIN). Complete this form in its entirety and **email it to ProviderRelations@deltadentalva.com** or fax it to 540.491.9709.

Tax ID Number (TIN) submitted on claims for this location _____

Type 2 Facility NPI _____

Business name (**as recorded with IRS on Form 941**) _____

Facility Address _____

☐ If enrolled in direct deposit, check here to have payment information transferred

**Opening date** _____/_____/_____

List all dentists providing services at the new location and which products they will participate in — a signed agreement will need to be attached for each dentist, for each product they will be participating in:

Name _____

License number _____ Type 1 Individual NPI _____

☐ Delta Dental Premier® ☐ Delta Dental PPO™ ☐ DeltaCare® ☐ Delta Dental Medicare Advantage™

Name _____

License number _____ Type 1 Individual NPI _____

☐ Delta Dental Premier ☐ Delta Dental PPO ☐ DeltaCare ☐ Delta Dental Medicare Advantage

Name _____

License number _____ Type 1 Individual NPI _____

☐ Delta Dental Premier ☐ Delta Dental PPO ☐ DeltaCare ☐ Delta Dental Medicare Advantage

Name _____

License number _____ Type 1 Individual NPI _____

☐ Delta Dental Premier ☐ Delta Dental PPO ☐ DeltaCare ☐ Delta Dental Medicare Advantage

**Note: a Facility Update form must be sent with this Additional Office Information Sheet.** The change will be made in our system as soon as we receive the appropriate forms. It is important to make these changes quickly to avoid delays in claims processing. Thank you for your prompt attention.

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# Facility Profile Form

Please complete a facility profile for each office location. If you have more than one location, copy or print additional copies of this page. Complete this form in its entirety and **email it to ProviderRelations@deltadentalva.com** or fax it to 540.491.9709.

Location name _____

Tax ID Number (TIN) _____ Type 2 facility NPI _____

Business name (**as recorded with IRS on Form 941)** _____

Main office email address (dentist newsletters, fee schedules, etc.) _____

Credentialing email address (for recredentialing notices) _____

Physical address _____

Payment address (for checks only, if different from physical address) _____

_____

Correspondence address (X-rays, provider updates and information other than checks)

_____

Phone_____ Fax _____

Office hours: Mon_____ Tues_____ Wed_____ Thurs_____ Fri_____ Sat_____ Sun_____

Are you accepting new patients? ☐ Yes ☐ No

Languages spoken (other than English)_____

Does this location have wheelchair access? ☐ Yes ☐ No

Public transit accessibility? ☐ Yes ☐ No

Treats physically disabled adults? ☐ Yes ☐ No Treats physically disabled children? ☐ Yes ☐ No

Offers telehealth/teledentistry services? ☐ Yes ☐ No

Are emergency services available 24 hours a day? ☐ Yes ☐ No

If yes, please check the type of service available: ☐ Home/cell phone number ☐ Another local dentist

Are all permits and filings required by law and regulation current and valid (i.e., radiographic equipment)? ☐ Yes ☐ No

Are all staff members trained in CPR? ☐ Yes ☐ No

Are all individuals treating patients fully licensed? ☐ Yes ☐ No