DELTA DENTAL®

Addition of Dentist Form

Complete this form in its entirety and **email it to ProviderRelations@deltadentalva.com** or fax it to 540.491.9709.

1. Demographics

Name of new dentist ______________________________

Dental License Number______________________ Type 1 Individual NPI ______________________

Tax ID Number______________________ Type 2 Facility NPI ______________________

Office Address ______________________________

Gender ______________________ Date of birth _____ /_____ /_____

Name of specialty, if applicable______________________ Start Date _____ /_____ /_____

Does the dentist wish to participate with Delta Dental at this facility? ☐ Yes ☐ No

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

2. Additional Locations

Are there additional locations where the new dentist will be working? ☐ Yes ☐ No

If so, then indicate the locations and the products they will participate in:

(Use a separate sheet to list more locations, if necessary.)

Address______________________ Tax ID______________ Start Date _____ /_____ /_____

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

Address______________________ Tax ID______________ Start Date _____ /_____ /_____

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

Address______________________ Tax ID______________ Start Date _____ /_____ /_____

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

3. Remove from Locations

Are there locations the new dentist is no longer practicing at? ☐ Yes ☐ No

Address______________________________ Tax ID ______________________

Address______________________________ Tax ID ______________________

Address______________________________ Tax ID ______________________

______________________________ _____/_____/_____

Dentist signature **Date**