



# Addition of dentist form

Complete this form in its entirety and email it to [ProfessionalRelations@deltadentalva.com](mailto:ProfessionalRelations@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®  Delta Dental 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  Delta Dental Medicare Advantage

Address \_\_\_\_\_ Tax ID \_\_\_\_\_ Start Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Delta Dental Premier  Delta Dental PPO  DeltaCare  Delta Dental Medicare Advantage

Address \_\_\_\_\_ Tax ID \_\_\_\_\_ Start Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Delta Dental Premier  Delta Dental PPO  DeltaCare  Delta Dental 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