DELTA DENTAL®

deltadentalid.com

Notice of Address or Additional Location Change

Start Date ☐

☐ Address Change
☐ Additional Location

NEW OFFICE INFORMATION

Practice Name	Address	City	State	Zip

(If more than one location please attach additional information)

Payment Address	City	State	Zip

Telephone Number	Fax Number	Office General Email address	Are You Accepting New Patients?
			☐ Yes ☐ No

Hours of Operation

Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:

Tax ID Type	Legal Business Name	Tax ID #	NPI Number- TYPE 2 (required for any practice that is a Corporation, LLC, PC, S Corp etc.)
☐ SSN ☐ EIN			

Business Type

Individual/Sole Proprietor	Corporation	Partnership	Single Member LLC

Do You Provide (please check all that apply)

Public Transit Accessibility:	☐ Yes ☐ No	Treatment for Cognitively Disabled Children:	☐ Yes ☐ No
Handicap Access:	☐ Yes ☐ No	Treatment for Physically Disabled Adults:	☐ Yes ☐ No
Treatment for Cognitively Disabled Adults:	☐ Yes ☐ No	Treatment for Physically Disabled Children:	☐ Yes ☐ No
Offers Telehealth Services:	☐ Yes ☐ No		

Dentist Information (Please list all dentists practicing at this new office location):

Dentist First Name	Middle Initial	Last Name	Idaho License #	Individual NPI (type 1):

I certify that all of the information herin is accurate and true to the best of my knowledge and agree to notify Delta Dental of Idaho, in writing, of any changes in this document within ten (10) days of their occurrence. I understand that willful and substantial omissions, misrepresentations and any information stated on this form, which subsequently if found to be false, could result in denial/termination of my participation with Delta Dental of Idaho.

A photocopy of this permission will be considered as valid as the original.

Dentist's Signature: _____

Typed or printed name: _____ Date: _____

Please return all information to:

Delta Dental of Idaho
ATTN: Provider Records
555 E. Parkcenter Blvd.
Boise, Idaho 83706
Email: providerservices@deltadentalid.com