DELTA DENTAL®

deltadentalins.com

TREATING PROFESSIONAL FORM

This form is to be used by a contracted Delta Dental billing dentist or dental entity to add or delete a contracted treating professional into or from a group or individual practice. This form can also be used to make changes to an existing treating professional (for example: name, specialty, etc.) **If you wish to update information for more than one treating professional, please use the second page to list all additional treating professionals.**

Note: All new treating professionals will be considered out of network until you receive a confirmation letter from Delta Dental with an effective date of enrollment.

BILLING DENTIST OR DENTAL ENTITY INFORMATION

1. Practice Owner or Partnership/Corporation/Clinic Officer (Last name/First name)	2. Group Practice/Clinic Name (as issued by the IRS)	
1a. Please indicate current Delta Dental network participation: ☐ Delta Dental Premier® network ☐ Delta Dental Premier and Delta Dental PPO℠ networks	3. ☐ **This applies to more than one Treating Professional.** (see page 2)	
4. DBA or Group/Clinic Name (if different from name issued by the IRS)	5. Tax ID Number	6. Business NPI (Type 2)
7. Office Address City State ZIP	8. Office Number ( ) Fax Number ( )	9. Email Address* _______________@_________________

***An email confirmation will be sent in addition to a hardcopy confirmation once this enrollment is complete.**

I certify that the information provided on this form is true, accurate and complete to the best of my knowledge. I understand that I must promptly report any changes of this information to Delta Dental.

Billing Dentist or Dental Entity Name and Title ______________ Signature of Billing Dentist or Dental Entity ______________ Date ______________

TREATING PROFESSIONAL INFORMATION

Treating Professional Name (Last, First, Initial) (DDS or DMD)

Please indicate current Delta Dental network participation:
- ☐ Delta Dental Premier® network
- ☐ Delta Dental Premier and Delta Dental PPO℠ networks
- ☐ Not participating in any Delta Dental networks (Must complete a Participating/Contracting Agreement and Confidential Credentialing form to be added to this location).

Individual NPI (Type 1)

Specialty Type: (New fees may apply for new specialty types at this location)

☐ General Dentist ☐ Oral Surgeon ☐ Periodontist
☐ Pediatric Dentist ☐ Endodontist ☐ Orthodontist
☐ Prosthodontist ☐ Oral Pathologist
☐ Other ________________________________

Date of Birth	Gender	Dental License #	Expiration Date	Start Date at Practice Location
____/____/________	☐ Male ☐ Female		____/____/________	____/____/________

Please indicate change requested:

☐ Add ☐ Delete ☐ Change/Update information Reason: ________________________________

I certify that the information provided on this form is true, accurate and complete to the best of my knowledge and I hereby affirm all provisions of my Delta Dental Participating/Contracting Agreement. I understand that I must promptly report any changes of this information to Delta Dental.

Treating Professional Name and Title ______________ Signature of Treating Professional ______________ Date ______________

Please ensure the billing dentist or dental entity and each Treating Professional complete, sign and return this document to your local Delta Dental (complete page two if this applies to more than one treating professional).

Delta Dental of California
ATTN: Provider File Maintenance
P.O. Box 537010
Sacramento, CA 95853-7010
Or dentist_services@delta.org
Fax: 916-852-8995

Delta Dental Insurance Company
ATTN: Provider File Maintenance
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009
Or dnac@ddic.delta.org
Fax: 770-641-5395
AL, FL, GA, LA , MS, MT, NV, TX, UT and U.S. Virgin Islands

Delta Dental of Pennsylvania (Mid-Atlantic Region)
ATTN: Provider File Maintenance
One Delta Drive
Mechanicsburg, PA 17055-6999
Or ddpdentist_services@deltadentalpa.org
Fax: 717-774-1770
Delta Dental of Delaware, Delta Dental of the District of Columbia, Delta Dental of Pennsylvania (Maryland), Delta Dental of West Virginia, Delta Dental of New York, Inc.

#71738 (5/13)

Tax Identification number: ____________________ **Office address:** ____

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Treating Professional Name and Title ____________________ Signature of Treating Professional ____________________ Date ____________

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Treating Professional Name and Title ____________________ Signature of Treating Professional ____________________ Date ____________