Provider Update Form - Provider Operations

You may send this form by e-mail to Sunlife.Provider.Updates@greatdentalplans.com
or StandardUpdates@greatdentalplans.com

Section 1: Current Information (Complete for ALL Requests - Asterisk denotes required fields)

*Effective Date (if different than current date): _____

*Provider Last Name: _____ *Provider First Name: _____

*Individual National Provider Identifier (NPI) #: _____

Date of Birth: _____ Social Security #: _____ Gender: _____

*Specialty: _____ *Personal Email: _____

Requestor Information

*Requestor Name: _____ *Title: _____

*Requestor Contact Information (Phone or Email): _____

Section 2: Type of Update - Check all that Apply (Complete for ALL Requests - For Questions contact your Dental Network Managers or Customer Service)

- ☐ Business (Tax ID) - Add/Term/Update - **Complete Sections 1, 6, 7 and 8**
- ☐ Credentialing Correspondence Change/Update - **Complete Sections 1 and 5**
- ☐ EFT/Payment - **Complete Sections 1 and 8**
- ☐ License Change - **Complete Sections 1 and 4**
- ☐ Name Change - **Complete Sections 1 and 3**
- ☐ Location - Add/Term/Update - **Complete Sections 1 and 6**
- ☐ Termination Request - **Complete Sections 1 and 9**

Section 3: Name Change (Attach supporting legal documentation)

New Last Name: _____ New First Name: _____

New Middle Name: _____ New Suffix: _____

Please Note: *Before your name can be changed in our system, your license must reflect the change.*

Section 4: License Change

New Dental License Number: _____ State: _____

New DEA License Number: _____ State: _____

New State Drug License Number: _____ State: _____

New Medicaid License Number: _____ State: _____

Other License Name: _____

Other License Number: _____ State: _____

Section 5: Credentialing Correspondence Change

Credentialing Contact Name: _____

Correspondence Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Credentialing E-Mail: _____

Section 6: Location Add/Term/Update (In order to link this provider/location, include documentation for Adds and Changes)

Please Note: *If you are adding a location, please indicate if any locations need to termed. If you have multiple location changes, please submit a separate form for each location.*

☐ Add ☐ Term ☐ Update

Tax ID Number: _____

Location Name: _____

Location Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Can this fax number accept PHI? ☐ Yes ☐ No Office Email: _____

Office Hours: Monday _____ Tuesday _____

Wednesday _____ Thursday _____

Friday _____ Saturday _____

Sunday _____ Ages Minimum: _____ Ages Maximum: _____

☐ Primary Location ☐ Handicapped Accessible

Office Languages: _____

Office URL: _____

Section 7: Business - (Tax ID) Add/Term/Update (Updated W9 required for all Adds and Updates - W9 Attached)

Please Note: *If you have multiple Tax ID changes, please submit a separate form for each Tax ID. If you are replacing a Tax ID, please complete both the current/old and new Tax ID information fields. Failure to do so will result may result in inaccurate claims processing and inaccurate directory information.*

Current/Old Tax ID Information

Current/Old Tax ID Retired Date: _____ Current/Old Business Name: _____

Current/Old Tax ID: _____ Current/Old Business NPI: _____

New Tax ID Information

New Tax ID Effective Date: _____ New Business Name: _____

New Tax ID: _____ New Business NPI: _____

Please Note: *A Business NPI (Type 2) is* ***required*** *for all business types except Sole Proprietors.*

Section 8: EFT/Payment (This only applies to claims directly administered or paid by Sun Life/DentaQuest)

Tax ID Number: _____

Payment Address: _____

City: _____ State: _____ Zip Code: _____

☐ Add EFT ☐ Cancel EFT ☐ Change EFT

Please Note: *The EFT Form will need to be completed for any Adds or Updates. This includes a copy of a voided check or a bank letter (attached).*

Section 9: Termination Request

☐ Term Provider at Location Listed Below Tax ID Number: _____

Please attach document with any additional locations to be termed.

☐ Term Provider at ALL Locations - ALL Networks

Please attach term letter, note or document from the provider that includes all locations to be termed as applicable.

☐ Term Business Tax ID Number: _____

Please attach a list of providers and locations that need to be terminated.

Location Name: _____

Location Address: _____

City: _____ State: _____ Zip Code: _____

Network(s) to Term[1]

☐ DHA (Dental Health Alliance, L.L.C.)

☐ PDG (The Premier Dental Group, Inc.)

☐ All applicable Sun Life prepaid/DHMO companies[2]

☐ DentaQuest

☐ DCP (Dental Care Plus, Inc.)

☐ CDN (California Dental Network, Inc.)

Term Reason - Select One

☐ Business Closed/Sold

☐ Deceased

☐ Not Seeing Members at this Location

☐ Provider No Longer at Location

☐ Retired

☐ Term for Broken Appointments

☐ Term for Low Fees

☐ Term per Provider

[1] When terminating your agreement with a network you will also be removed from all clients that access that network.

[2] Affiliated prepaid/DHMO companies are: Denticare of Alabama, Inc., United Dental Care of Arizona, Inc., UDC Dental California, Inc., United Dental Care of Colorado, Inc., Union Security DentalCare of Georgia, Inc., United Dental Care of Missouri, Inc., Union Security Dentalcare of New Jersey, Inc., United Dental Care of New Mexico, Inc., UDC Ohio, Inc., and United Dental Care of Texas, Inc.

Notes