

# Provider Update Form - Provider Operations

You may send this form by e-mail to Standardupdates@greatdentalplans.com or by fax to 262-241-4077

## 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 E-Mail

## Requestor Information

\*Requestor Name

\*Title

\*Requestor Contact Information (Phone or E-mail)

## Section 2: Type of Update - Check all that Apply - Complete for ALL Requests - For Questions contact your Provider Engagement Representative 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

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**Section 6: Location Add/ Term/ Update - In order to link this provider/location to an existing contract, include documentation for Adds and Changes that include the below information on Company Letterhead.**

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

<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> Update	
Tax ID Number	<input type="text"/>	Medicaid ID (if applicable)	<input type="text"/>
Location Name <input type="text"/>			
Location Address <input type="text"/>			
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>
Is this location a Mobile Dental Unit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Telehealth Services Available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Telephone	<input type="text"/>	Fax	<input type="text"/>
Can this fax number accept PHI?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Office E-Mail <input type="text"/>			
Office Hours	Monday - <input type="text"/>	Tuesday - <input type="text"/>	
	Wednesday - <input type="text"/>	Thursday - <input type="text"/>	
	Friday - <input type="text"/>	Saturday - <input type="text"/>	
	Sunday - <input type="text"/>	Ages Minimum <input type="text"/>	Ages Maximum <input type="text"/>
<input type="checkbox"/> Primary Location	<input type="checkbox"/> Handicapped Accessible		
Office Languages <input type="text"/>			
Office URL <input type="text"/>			
Provider Weekly Working Hours i.e 5, 10, 15, 20 <input type="text"/>			

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

**Please Note:** If you are adding or changing a Tax ID, please indicate any existing Tax IDs that need to be terminated. If you have multiple Tax ID changes, please submit a separate form for each Tax ID.

<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> Update	
Old/ Current Tax ID Number	<input type="text"/>	New Tax ID Number	<input type="text"/>
Business Name <input type="text"/>			
Business Address <input type="text"/>			
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>
Telephone	<input type="text"/>	Fax	<input type="text"/>
Office E-Mail <input type="text"/>			
Group NPI <input type="text"/>			

**Please Note:** A Group NPI for all business types except Sole Proprietors.

Will you have any outstanding claims to submit under the old/current Tax ID Number?

If yes, please provide a date of when all claims will be submitted by: \_\_\_\_\_

Yes

No

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### Section 8: EFT/ Payment

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.**

Term Reason/ Comments

Location Name

Location Address

City

State

Zip Code

### Notes