2025 Delta Dental of Oregon Medicare Advantage termination request

I, _____ [name], Dentist, wish to terminate my participation in Delta Dental of Oregon's Medicare Network effective December 31, 2024. I acknowledge this termination only terminates the Medicare Exhibit of my Agreement and that my Participating Dentist Agreement Government Programs will remain in full force and effect after December 31, 2024 if my contract includes a Medicaid Exhibit.

Signature X
Name of Practice
TIN/EIN

Ready to submit? Mail this form to Delta Dental:

Attn: Dental Professional Relations
Mail: 601 SW Second Ave., Portland OR, 97240-0384
Fax: 503-243-3965

Questions? We're here to help. Contact the Delta Dental Professional Relations at 888-374-8905. (TTY users, dial 711.)

DeltaDentalOR.com