DELTA DENTAL

Notice of Address Change

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This form should be used by the contracted Delta Dental business owner ("billing entity") to report an address change. You will be notified by email when your information is updated in our system, generally within 30 days of our receipt of this form. Please do not submit claims with your new address until you receive confirmation that your records have been updated.

Please note: This form should not be used when adding an additional practice location or a new dentist. These forms can be found on our website under resources.

BUSINESS INFORMATION (Please complete this section)

Business Owner or Partnership/Corporation/Clinic Officer (last name, first name)

Legal name of person, partnership or business in which TIN was issued by the IRS

Business name "doing business as", if different from legal name above

Taxpayer Identification Number (TIN):

Business NPI (Type 2), if applicable

PRACTICE LOCATION ADDRESS CHANGE (Use this section to update your practice location address)

Closed Practice Location Information

Street Address _____

City _____

State _____ ZIP Code _____

Email _____

Phone ( ) _____

Fax ( ) _____

New Practice Location Information

Street Address _____

City _____

State _____ ZIP Code _____

Email _____

Phone ( ) _____

Fax ( ) _____

Please indicate the date this change will be effective: (Note: we are unable to accept dates more than 60 days in advance)

Also apply this new Practice Location address to update my: ☐ Mailing Address and/or ☐ 1099/TIN Mailing Address.

(continued next page)

MAILING ADDRESS CHANGE (Use this section to update your mailing address)

Old Mailing Address Information

Street/P.O. Box _____

City _____

State _____ ZIP Code _____

Phone (___) _____

New Mailing Address Information

Street/P.O. Box _____

City _____

State _____ ZIP Code _____

Phone (___) _____

Please indicate the date this change will be effective: (Note: we are unable to accept dates more than 60 days in advance)

_____

1099/TIN MAILING ADDRESS CHANGE (Use this section to update your 1099/TIN mailing address)

Old 1099/TIN Mailing Address Information

Street/P.O. Box _____

City _____

State _____ ZIP Code _____

Phone (___) _____

New 1099/TIN Mailing Address Information

Street/P.O. Box _____

City _____

State _____ ZIP Code _____

Phone (___) _____

Please indicate the date this change will be effective: (Note: we are unable to accept dates more than 60 days in advance)

_____

☐ I certify that the information provided on this form is true, accurate and complete to the best of my knowledge. I have the authority to make these changes. I understand that Delta Dental will inactivate my former address 30 days from the date the new address is effective. I also understand that I must promptly report any change to this information to Delta Dental.

Billing Provider Name (Name and Title)	Signature of Billing Provider	Date

Please return the completed form to:

Mailing address: Attn: Dental Professional Relations, 601 SW Second Ave, Portland OR 97204
Fax Number: 503-243-3965
Email for Oregon: dpror@deltadentalor.com
Email for Alaska: dprak@deltadentalak.com

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