



Provider Add/Remove Request Effective Date Please select: Add provider \Box Remove provider \Box Clinic Name _____ **Provider Information:** Location address _____ Office phone number _____ For temporary providers: Start Date: _____ End Date: ____ If this request is for more than one location, please list all additional addresses below. List provider on the Delta Dental Directory: YES \square NO \square

For Oregon, please email the completed form to dpror@deltadentalor.com. For Alaska, please use dpror@deltadentalor.com. The form may also be faxed to 503-243-3965 for processing.