

Change request form.

Date _____ Provider Relations Representative _____

- Add a Provider (adding a provider to a participating group)
- Delete a Provider (deleting a provider from a participating group)
- Demographic Change

Specify the demographic change: Practice location change Specialty change
 Ownership/TIN change NPI/phone/fax change
 Network Participation add/delete (attach W9)

Effective Date of Change _____

Group Name (as listed on W9) _____ Practice Name _____

Group Tax ID Number _____ Provider Name _____

Contact Name _____

Contact Phone _____ Contact Email _____

Practice Address _____

City _____ State _____ ZIP code _____

Is this practice accepting new patients? Yes No

Is the billing address the same as above? If not, please fill in the billing information below.

Same as Above

Billing Street _____

City _____ State _____ ZIP code _____

What is the change you are requesting? _____

Who does this change affect?

Name	License	NPI	Date Effective

If this update requires a tax ID change, please send a W9.

You may return this form to:
The Dental Care Plus Group
Attn: Provider Relations
100 Crowne Point Place / Cincinnati, Ohio 45241
Fax: (513) 618-3881
Email: providerrelations@dentalcareplus.com

**For questions, please contact DCPG's provider relations department at
(800) 367-9466 or (513) 554-1100.**

T H E P L U S I S S E R V I C E