

Dental Provider Change of Data Form

Please use this form to indicate changes in your data. Complete applicable sections. Only If payment to a clinic or group is required, please complete an **Authorization for Clinic Billing** form. Practitioners wishing to use an Employer Identification Number (EIN) for payment must submit verification of EIN (Letter 147C, CP 575 E, or tax coupon 8109-C). Please type or print.

Forms can be emailed to dentalproviderrelations@usablelife.com or faxed to 501-208-8302.

Forms can also be mailed to: **Dental Provider Network Operations PO Box 1650 Little Rock AR 72203.**

Primary Practice Location

Additional Location

Name _____ NPI _____
(First, MI, Last)

Doing Business As _____

Change Effective Date _____ Medical Records Fax # _____

Specialty _____ Secondary Specialty _____

Primary Language _____ Secondary Languages _____

AR License/Certification # _____ Issue Date _____ Expiration Date _____

Other License/Certification # _____ ST _____ Issue Date _____ Expiration Date _____

DEA # _____ ST _____ Issue Date _____ Expiration Date _____
(Attach copy of certificate)

Email Address _____

Primary Credentialing Contact Person _____ Title _____

PRIMARY PRACTICE LOCATION - Must have a street address

Practice Location Address _____

Phone # to be used for Patient Appointments _____ Fax # _____

Office hours at this location-

Open/Close	Open/Close	Open/Close	Open/Close	Open/Close	Open/Close	Open/Close
Mon. _____	Tues. _____	Wed. _____	Thurs. _____	Fri. _____	Sat. _____	Sun. _____

CORRESPONDENCE INFORMATION - For notifications, newsletters, credentialing updates, etc.

Correspondence Address _____

Correspondence Phone # _____ Fax # _____

PAYMENT INFORMATION - If payment to a clinic or group is required, please complete the *Authorization for Clinic Billing* form and do not complete payment information.

Payment EIN or SS# _____
(Attach IRS verification of EIN)

Payment Name _____

Payment Address _____

Payment Phone # _____ Payment Fax # _____

Print Name of Individual Practitioner _____

Signature _____ Date _____
(Individual Practitioner- NO STAMPS)

ADDITIONAL LOCATIONS*

❖ Location Name _____
Address _____
Phone _____ Fax _____
Office hours at this location-
Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close
Mon. _____ Tues. _____ Wed _____ Thurs. _____ Fri. _____ Sat. _____ Sun. _____

❖ Location Name _____
Address _____
Phone _____ Fax _____
Office hours at this location-
Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close
Mon. _____ Tues. _____ Wed _____ Thurs. _____ Fri. _____ Sat. _____ Sun. _____

❖ Location Name _____
Address _____
Phone _____ Fax _____
Office hours at this location-
Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close
Mon. _____ Tues. _____ Wed _____ Thurs. _____ Fri. _____ Sat. _____ Sun. _____

❖ Location Name _____
Address _____
Phone _____ Fax _____
Office hours at this location-
Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close
Mon. _____ Tues. _____ Wed _____ Thurs. _____ Fri. _____ Sat. _____ Sun. _____

❖ Location Name _____
Address _____
Phone _____ Fax _____
Office hours at this location-
Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close Open/Close
Mon. _____ Tues. _____ Wed _____ Thurs. _____ Fri. _____ Sat. _____ Sun. _____

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