



Addition of Dentist Form

Complete this form in its entirety and email it to ProviderRelations@deltadentalva.com or fax it to 540.491.9709.

1. Demographics

Name of new dentist _____

Dental License Number _____ Type 1 Individual NPI _____

Tax ID Number _____ Type 2 Facility NPI _____

Office Address _____

Gender _____ Date of birth ____/____/____

Name of specialty, if applicable _____ Start Date ____/____/____

Does the dentist wish to participate with Delta Dental at this facility? Yes No

Delta Dental Premier® Delta Dental PPO™ DeltaCare®

2. Additional Locations

Are there additional locations where the new dentist will be working? Yes No

If so, then indicate the locations and the products they will participate in:

(Use a separate sheet to list more locations, if necessary.)

Address _____ Tax ID _____ Start Date ____/____/____

Delta Dental Premier Delta Dental PPO DeltaCare

Address _____ Tax ID _____ Start Date ____/____/____

Delta Dental Premier Delta Dental PPO DeltaCare

Address _____ Tax ID _____ Start Date ____/____/____

Delta Dental Premier Delta Dental PPO DeltaCare

3. Remove from Locations

Are there locations the new dentist is no longer practicing at? Yes No

Address _____ Tax ID _____

Address _____ Tax ID _____

Address _____ Tax ID _____

_____/_____/_____
Dentist signature Date

For questions, or to check the status of the change in our system, contact Provider Relations at 800.367.3531, extension 3328.