Provider Update Form - Provider Operations

You may send this form by e-mail to Standardupdates@greatdentalplans.com or by fax to 262-241-4077

Section 1: Current Information - *Complete for ALL Requests - Asterisk denotes required fields*

***Effective Date *(if different than current date)* :**

*Provider Last Name | *Provider First Name

*Individual National Provider Identifier (NPI) #

Date of Birth | Social Security # | Gender

*Specialty | *Personal E-Mail

Requestor Information

*Requestor Name | *Title

*Requestor Contact Information *(Phone or E-mail)*

Section 2: Type of Update - Check all that Apply - *Complete for ALL Requests -* For Questions contact your Provider Engagement Representative or Customer Service

- ☐ Business (Tax ID) - Add/ Term/ Update - **Complete Sections 1, 6, 7 and 8**
- ☐ Credentialing Correspondence Change/Update - **Complete Sections 1 and 5**
- ☐ EFT/ Payment - **Complete Sections 1 and 8**
- ☐ License Change - **Complete Sections 1 and 4**
- ☐ Name Change - **Complete Sections 1 and 3**
- ☐ Location - Add/ Term/ Update - **Complete Sections 1 and 6**
- ☐ Termination Request - **Complete Sections 1 and 9**

Section 3: Name Change - *Attach supporting legal documentation*

New Last Name | New First Name

New Middle Name | New Suffix

Please Note: Before your name can be changed in our system, your license must reflect the change.

Section 4: License Change

New Dental License Number | State

New DEA License Number | State

New State Drug License Number | State

New Medicaid License Number | State

Other License Name

Other License Number | State

Section 5: Credentialing Correspondence Change

Credentialing Contact Name

Correspondence Address

City | State | Zip Code

Telephone | Fax

Credentialing E-Mail

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Section 6: Location Add/ Term/ Update - In order to link this provider/location to an existing contract, include documentation for Adds and Changes that include the below information on Company Letterhead.

☐ Add ☐ Term ☐ Update

Tax ID Number ______ Medicaid ID (if applicable) ______

Location Name ______

Location Address ______

City ______ State ______ Zip Code ______

Is this location a Mobile Dental Unit? ☐ Yes ☐ No

Telehealth Services Available? ☐ Yes ☐ No

Telephone ______ Fax ______

Can this fax number accept PHI? ☐ Yes ☐ No

Office E-Mail ______

Office Hours Monday - Tuesday -

Wednesday - Thursday -

Friday - Saturday -

Sunday - Ages Minimum ______ Ages Maximum ______

☐ Primary Location ☐ Handicapped Accessible

Office Languages ______

Office URL ______

Provider Weekly Working Hours i.e 5, 10, 15, 20 ______

Section 7: Business - (Tax ID) Add/ Term/ Update - *Updated Contract and W9 required for all Adds and Updates - W9 Attached*

☐ Add ☐ Term ☐ Update

Old/ Current Tax ID Number ______ New Tax ID Number ______

Business Name ______

Business Address ______

City ______ State ______ Zip Code ______

Telephone ______ Fax ______

Office E-Mail ______

Group NPI ______

Please Note: A Group NPI is needed for all business types except Sole Proprietors.

Will you have any outstanding claims to submit under the old/current Tax ID Number?
If yes, please provide a date of when all claims will be submitted by: ________________ ☐ Yes ☐ No

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Section 8: EFT/ Payment

Tax ID Number ____

Payment Address ____

City ____ State ____ Zip Code ____

☐ Add EFT   ☐ Cancel EFT   ☐ Change EFT

Please Note: The EFT Form will need to be completed for any Adds or Updates. This includes a copy of a voided check or a bank letter (attached)

Section 9: Termination Request

☐ Term Provider at Location Listed Below   Tax ID Number ____

Please attach document with any additional locations to be termed.

☐ Term Provider at ALL Locations - ALL Networks

Please attach term letter, note or document from the provider that includes all locations to be termed as applicable.

☐ Term Business   Tax ID Number ____

Please attach a list of providers and locations that need to be terminated.

Term Reason/ Comments ____

Location Name ____

Location Address ____

City ____ State ____ Zip Code ____

Notes