

Provider Update Form - Provider Operations

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

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

Change Effective Date (Required) :

*Provider Last Name <input style="width: 95%;" type="text"/>	*Provider First Name <input style="width: 95%;" type="text"/>
*Individual National Provider Identifier (NPI) # <input style="width: 95%;" type="text"/>	
Date of Birth <input style="width: 150px;" type="text"/>	Social Security # <input style="width: 150px;" type="text"/>
Gender <input style="width: 100px;" type="text"/>	
*Specialty <input style="width: 300px;" type="text"/>	*Personal E-Mail <input style="width: 200px;" type="text"/>

Requestor Information

*Requestor Name <input style="width: 95%;" type="text"/>	*Title <input style="width: 95%;" type="text"/>
*Requestor Contact Information (Phone or E-mail) <input style="width: 95%;" type="text"/>	

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, 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 <input style="width: 95%;" type="text"/>	New First Name <input style="width: 95%;" type="text"/>
New Middle Name <input style="width: 150px;" type="text"/>	New Suffix <input style="width: 150px;" type="text"/>

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

Section 4: License Change

New Dental License Number <input style="width: 95%;" type="text"/>	State <input style="width: 95%;" type="text"/>
New DEA License Number <input style="width: 95%;" type="text"/>	State <input style="width: 95%;" type="text"/>
New State Drug License Number <input style="width: 95%;" type="text"/>	State <input style="width: 95%;" type="text"/>
New Medicaid License Number <input style="width: 95%;" type="text"/>	State <input style="width: 95%;" type="text"/>
Other License Name <input style="width: 95%;" type="text"/>	
Other License Number <input style="width: 95%;" type="text"/>	State <input style="width: 95%;" type="text"/>

Section 5: Credentialing Correspondence Change

Credentialing Contact Name <input style="width: 95%;" type="text"/>		
Correspondence Address <input style="width: 95%;" type="text"/>		
City <input style="width: 150px;" type="text"/>	State <input style="width: 50px;" type="text"/>	Zip Code <input style="width: 100px;" type="text"/>
Telephone <input style="width: 150px;" type="text"/>	Fax <input style="width: 150px;" type="text"/>	
Credentialing E-Mail <input style="width: 95%;" type="text"/>		

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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.

<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> Update
Tax ID Number		Medicaid ID (if applicable)
Location Name		
Location Address		
City	State	Zip Code
Is this location a Mobile Dental Unit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Telephone		Fax
Can this fax number accept PHI?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Office E-Mail		
Office Hours	Monday -	Tuesday -
	Wednesday -	Thursday -
	Friday -	Saturday -
	Sunday -	Ages Minimum
		Ages Maximum
<input type="checkbox"/> Primary Location	<input type="checkbox"/> Handicapped Accessible	
Office Languages		

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

<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> 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: DentaQuest requires a Group NPI 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

Section 8: EFT/ Payment

Tax ID Number		
Payment Address		
City	State	Zip Code
<input type="checkbox"/> Add EFT	<input type="checkbox"/> Cancel EFT	<input type="checkbox"/> Change EFT

Please Note: The DentaQuest 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)

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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

Section 10: Type of Update - Check all that Apply - Complete for ALL Requests - Internal Use ONLY

- Product(s) Add/ Update/ Term- **Complete Sections 1, 10 and Notes**
- Claims Issue(s) - **Complete Sections 1, 10 and Notes**
- Dental Home - **Complete Sections 1, 10 and Notes**
- Fee Schedule Add - **Complete Sections 1, 10 and Notes**
- Fee Schedule Change - **Complete Sections 1, 10 and Notes**
- Provider Rule Add - **Complete Sections 1, 10 and Notes**
- Provider Rule Change - **Complete Sections 1, 10 and Notes**

Notes

Large empty box for notes.

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Additional 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.

<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> Update	
Tax ID Number	<input type="text"/>	Medicaid ID (if applicable)	<input type="text"/>
Location Name	<input type="text"/>		
Location Address	<input type="text"/>		
City	<input type="text"/>	State	<input type="text"/>
		Zip Code	<input type="text"/>
Is this location a Mobile Dental Unit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Telephone	<input type="text"/>	Fax	<input type="text"/>
Can this fax number accept PHI?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Office E-Mail	<input type="text"/>		
Office Hours	Monday - <input type="text"/>	Tuesday - <input type="text"/>	
	Wednesday - <input type="text"/>	Thursday - <input type="text"/>	
	Friday - <input type="text"/>	Saturday - <input type="text"/>	
	Sunday - <input type="text"/>	Ages Minimum <input type="text"/>	Ages Maximum <input type="text"/>
<input type="checkbox"/> Primary Location	<input type="checkbox"/> Handicapped Accessible		
Office Languages	<input type="text"/>		