DentaQuest

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 | *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, 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 DentaQuest can change your name in our system, your license must reflect the name 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

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

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***

☐ 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: 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

☐ Add EFT ☐ Cancel EFT ☐ 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

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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.

☐ 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

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