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 PNODental@arkbluecross.com or faxed to 501-210-7005.

Forms can also be mailed to: Dental Provider Network Operations PO Box 2181 Little Rock AR 72203-2181.

○ 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 Mon. _______ Open/Close Tues. ________ Open/Close Wed__________ Open/Close Thurs._________ Open/Close Fri.___________ Open/Close Sat._________ Open/Close Sun.________

- Location Name ______________________________

  Address______________________________

  Phone ______________________ Fax ______________________

  Office hours at this location-

  Open/Close Mon. _______ Open/Close Tues. ________ Open/Close Wed__________ Open/Close Thurs._________ Open/Close Fri.___________ Open/Close Sat._________ Open/Close Sun.________

- Location Name ______________________________

  Address______________________________

  Phone ______________________ Fax ______________________

  Office hours at this location-

  Open/Close Mon. _______ Open/Close Tues. ________ Open/Close Wed__________ Open/Close Thurs._________ Open/Close Fri.___________ Open/Close Sat._________ Open/Close Sun.________

- Location Name ______________________________

  Address______________________________

  Phone ______________________ Fax ______________________

  Office hours at this location-

  Open/Close Mon. _______ Open/Close Tues. ________ Open/Close Wed__________ Open/Close Thurs._________ Open/Close Fri.___________ Open/Close Sat._________ Open/Close Sun.________

- Location Name ______________________________

  Address______________________________

  Phone ______________________ Fax ______________________

  Office hours at this location-

  Open/Close Mon. _______ Open/Close Tues. ________ Open/Close Wed__________ Open/Close Thurs._________ Open/Close Fri.___________ Open/Close Sat._________ Open/Close Sun.________

*This page may be copied for additional location