

Change request form.

Date _____ Provider Relations Representative _____

- Add a Provider (adding a provider to a participating group)
- Delete a Provider (deleting a provider from a participating group)
- Demographic Change
 - Specify the demographic change: Practice location change Specialty change
 - NPI/phone/fax change Product add/delete

Group Name (as listed on W9) _____ Practice Name _____

Group Tax ID Number _____ Provider Name _____

Contact Name _____

Contact Phone _____ Contact Email _____

Practice Address _____

City _____ State _____ Zip _____

Is the billing address the same as above? If not, please fill in the billing information below.

- Same as Above

Billing Street _____

City _____ State _____ Zip _____

What is the change you are requesting?

Who does this change affect? _____

Name	License	NPI	Date Effective

If this update requires a tax ID change, please send a W9.

You may return this form to:
The Dental Care Plus Group
Attn: Provider Relations
100 Crowne Point Place / Cincinnati, Ohio 45241
Fax: (513) 618-3881
Email: providerrelations@dentalcareplus.com

**For questions, please contact DCPG's provider relations department at
(800) 367-9466 or (513) 554-1100.**

T H E P L U S I S S E R V I C E