# Provider Address Add/Change/Term Form

GEHA Connection Dental Network

urac ACCREDITED Dental Network Expires 08/01/2022

***Instructions:*** *Copy this form for additional locations. [ ] Check here if this is an additional page.*
*Return completed form(s) to:* ***CDact@geha.com***

| | | |
|---|---|---|
| Person completing this form (if different than provider) | First name: | Last name: |
| Contact email: | | Phone: |

## General information
PLEASE COMPLETE EACH SECTION IN BLACK INK. IF A QUESTION IS NOT APPLICABLE, WRITE "N/A." ALL SECTIONS MUST BE COMPLETED

| | | | |
|---|---|---|---|
| Last name: | First name: | MI: | Suffix: |
| Other names known by: | | Degrees: DDS ☐ DMD ☐ BDS ☐ MD ☐ Other ☐ | |
| Social Security Number: | Male ☐ Female ☐ | Date of birth: | |
| NPI 1 (Individual): | Languages other than English spoken by dentist: | | |
| Dentist's professional email (used on CV) *This will not be used in directories or solicitation*: | | | |

## License and identification numbers
PLEASE LIST ALL STATE LICENSES YOU HAVE HELD, CURRENT DEA and SDC **IF NONE, CONSIDERED WAIVERED*

License and identification numbers (attach additional pages if necessary)

| State | License number | License status | | Federal DEA number (copy required) | DEA Exp (MM/YY) | | | State Drug Certificate number | SDC status | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Active | Inactive | | Active - Exp Date MM/YY | In Process MM/YY | *No DEA | | Active | Inactive | N/A |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

*By selecting 'No DEA' I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management.

## Practice details: Add this location ☐ Term this location ☐ Update this location ☐

| | | | | |
|---|---|---|---|---|
| Office name: | | | Start date: | Part time ☐ Full time ☐ |
| Phone number: | | | Fax number: | |
| Physical address: | Suite number: | City: | State: | ZIP: |
| Office Manager name: | | | Office manager email address: | |
| Location affiliated with dental group? Yes ☐ No ☐ | Group name: | | NPI 2 (organization): | |
| Patient directory email: | | | Business email: | |
| Tax ID name: | | | Tax ID: | |
| Is this location an Essential Community Provider? Yes ☐ No ☐ | | | Indian Health Services location? Yes ☐ No ☐ | |
| Term reason: | | | | |

## Complete these fields if different from physical address:

| | | | | |
|---|---|---|---|---|
| Billing or remit address | | | Mailing address | |
| Billing city | Billing state | Zip | City | |
| Billing phone | Billing fax | Pay to name | State | Zip |

## Office services

| | | | |
|---|---|---|---|
| Accepts new patients | Yes ☐ No ☐ | Evening hours: | Yes ☐ No ☐ |
| Medicare patients? | Yes ☐ No ☐ | Include in Directory: | Yes ☐ No ☐ |
| Medicaid patients? | Yes ☐ No ☐ | Does this location offer Teledentistry: | Yes ☐ No ☐ |
| Handicap access? | Yes ☐ No ☐ | If yes, what platform is utilized? | |
| Are there any changes that affect your availability to patients? | Yes ☐ No ☐ | What form of Teledenstisty is performed? Asynchronous – Store & Forward Indirect Conference ☐ Synchronous – Live Audio/ Video Conference ☐ | |
| Same-day appointments? | Yes ☐ No ☐ | | |
| Difficult to schedule new patients? | Yes ☐ No ☐ | Do you provide dental services via Mobile Dentistry | Yes ☐ No ☐ |
| 24/7 coverage? | Yes ☐ No ☐ | If yes, what city & state does the Mobile Dentistry provide service in? | |
| Patient age limit? | Minimum age: Maximum age: | What services do you perform via the Mobile Dentistry? Diagnostic ☐ Preventative ☐ Restorative ☐ Other ☐ | |
| Weekend hours: | Yes ☐ No ☐ | | |
| Languages spoken by staff, other than English: | | Where is the Mobile Dentistry service performed? Off-site patient/customer location ☐ Mobile Dentistry vehicle ☐ | |

| Office Hours | Mon | | Tues | | Wed | | Thurs | | Fri | | Sat | | Sun | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|