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

Provider Update Form - Provider Operations

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)

Provider Update Form - Provider Operations

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

Provider Update Form - Provider Operations

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 [   ]