



Addition of Office Location Form

Today's Date	
First Dental Health Rep	
Office Contact/Attention	
Office Contact Email	
Dentist Full Name (print)	
Dentist License #	
Individual NPI	

If we receive this form before the **20th** day of the current month the new individual location shown below will be active in the First Dental Health PPO Network on the 1st day of the current month. If received on or after the 20th day of the current month, the new location will be active the 1st of the following month.

Please **INITIAL** next to the First Dental Health **additional** network(s) you are opting to join at this location

_____ EPO (CA only) _____ ACCESS (CA/AZ only) _____ PPO PLUS (NV/AZ only)
 (Initial to Add) (Initial to Add) (Initial to Add)

Office Location:

Please provide additional office locations on a separate [Addition of Office Location](#) form.

Practice Name: _____

Office Address: _____

City, State & Zip: _____

Office Phone Number: _____ Office Fax Number: _____

****Please include a W-9 Form for each new office location****

Name on W-9: _____

(Line 1 of W-9 Form / Name being filed with the I.R.S)

Tax ID Number: _____ Is the Office wheelchair Accessible? Yes No

Office Email Address for Public Directory: _____

Non-English Languages spoken in the office: _____

Dentist Signature: _____

(Signature of Dentist being added is required to process request)

License #: _____ Date: _____

Please return this completed form(s) and W- 9 by email, fax or mail to First Dental Health
 P.O. BOX 919029 San Diego, CA 92191 | providerrelations@firstdentalhealth.com | Fax: (866) 613-6381

This office will receive a written confirmation upon the processing of this request

FOR FIRST DENTAL HEALTH USE ONLY: PLEASE DO NOT WRITE BELOW THIS LINE

Office Contact:	Data Entry Date:	
Contact Phone:	Effective Date:	Processed by Initials: