First Dental Health

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

Name on W-9: _____ **Tax ID Number:** _____
(***Please include a W-9 Form for each new office location addition)***

Non-English Languages spoken in the office: _____

Is the Office wheelchair Accessible? Yes No **Office Email Address:** _____

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

License #: _____ **Date:** _____

Please return this completed form(s) and W- 9 within 30 days to prevent a possible interruption to your contract status. Please send 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:**	**Mailed Welcome Packet Date:**
Contact Phone:	**Effective Date:**	**Processed by Initials:**
	Processed by Initials:	