First Dental Health

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

Office Relocation Form

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 list additional office locations on a separate Addition of Office Location Form.*

Include a completed W-9 Form for each new office location addition

New Practice Location Name: _____ Effective Date _____

Office Address: _____

City, State & Zip: _____

Phone Number: _____ Fax Number: _____

Office Email: _____ Wheel Chair Accessible**:** Yes__ No__

Name on W-9: _____ Tax ID Number: _____

Non-English Languages Spoken: _____

Per your signed contract with First Dental Health, we will remove this former office from the First Dental Health network(s) after your new location is active.

Former Office Address: _____

City, State & Zip Code: _____

Dentist Signature_____ **License #:** _____**Date:** _____

(Signature of Dentist needed to process request)

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.

First Dental Health PO Box 919029 San Diego, CA 92191|providerrelations@firstdentalhealth.com | F: 866-613-6381

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

FOR OFFICE 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:	