Today's Date	
Office Contact/ Attention	
Office Email Address	
Dentist Full Name (print)	
Dentist License #	
Provider NPI	

Addition of Office Location

In accordance with the Dentist's signed Provider Agreement, the office location indicated below will be added to the First Dental Health PPO network within 10 business days from receipt of this form by First Dental Health. ***Please include a W-9 Form for each new office location addition.*** A written confirmation will be mailed to each office upon receipt of this form.

Please List Office Location:

Please provide additional office locations on a separate Addition of Office Location form.

Please ensure to INITIAL next to the First Dental Health 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)

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**

Dentist Signature: ____

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

License #:___________________________________ **Date:** ____

Please return this completed form(s) by email, fax or mail to First Dental Health

P.O. BOX 919029 San Diego, CA 92191| providerrelations@firstdentalhealth.com| Fax: (866) 613-6381

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

Data Entry Date:	Mailed Welcome Packet Date:
Effective Date:	
Processed by Initials:	Processed by Initials:

www.FirstDentalHealth.com

Web 7/2017