Provider Information Demographic Change Submission Form

United Healthcare | Dental Benefit Providers

Description of when to use form: To be used by provider if the provider has made changes to ANY of their demographic information (name change, address change, TIN change, etc.). *Form must be signed at bottom to be processed. Please list all providers associated with this change.* ***Failure to sign, list all associated providers requesting the update or attach required documentation will delay your request.***

Providers: To ensure your claims are processed correctly and on a timely basis, if you have had any changes to your demographic information, please ensure you submit your demographic changes **PRIOR** to submitting your claim(s) and within 30 days of the change taking place. For real-time updates and to reduce turn around times by 3-5 days, please visit the Self Service section after registration and log-in on **uhcdental.com**

Please check **ALL** the demographic items that **need** to be updated and complete all sections as appropriate. Please submit completed form using one of the methods to the right on this box:

Mailing Address: Dental Benefit Providers, Inc. (DBP-CA Inc)
ATTN: Dental Provider Services
PO Box 30567, Salt Lake City UT 84130
Fax: 248-733-6372
Email: dbpprvfx@uhc.com

☐ Please check box if making a TIN (Tax ID Number) change. (***Copy of updated W-9 form is required***) ***May be subject to new contracting.***

Current Tax ID:	**New Tax ID:**	**Effective date of change :**	**Reprocess Claims? :** ☐ ***Yes***

☐ Please check box if making a dentist name change. (***Copy of updated dental license is required***)

Current Name: (Last) (First)

New Name: (Last) (First)

☐ Please check box if changing specialty. (***Copy of specialty certification is required***) ☐ Please check box if board certified.

Effective date of the following information change: ☐ Please check if office is handicap accessible.

☐ Please check box if ***updating practice name or address***

PRACTICE LOCATION:

(Only complete applicable fields)

Previous Practice Name:	**New Practice Name:**
Previous Physical Address: (Suite #)	**New Physical Address:** (Suite #)
(City) (State) (Zip)	(City) (State) (Zip)

☐ Please check box if ***updating mailing address***

REMITTANCE ADDRESS:

(Only complete applicable fields)

☐ Please check box if ***remit is same as office location***

Previous Remit Address: (Suite #)	**New Remit Address** (Suite #)
(City) (State) (Zip)	(City) (State) (Zip)

ADDITIONAL DEMOGRAPHIC INFORMATION

(Only complete applicable fields)

Languages Spoken Other Than English:	**Directory Office website:**	**Directory Email Address:**
Phone Number:	**Fax Number:**	**Internal Email Address:**

New Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun

☐ ***Please check box if Associate Provider(s) need to be termed.*** **Term Reason:** ☐ **Provider Left Practice** ☐ **Other**

Provider(s) associated with the requested change:

Notice*** ***Effective Date*** *may be different than the date of signature on this form. Please be sure your effective date reflects the actual date the change took place.*

AUTHORIZED SIGNATURE: **DATE:**