



DINA DENTAL PROVIDER CHANGE FORM

Add Provider Remove Provider Add Location Delete Location Change TIN

Currently participate in: PPO DHMO Medicaid/Medicare All

Market: TX LA MO TN ALL OTHERS

Check One		Provider Name	NPI #	Contact Email	Contact Phone #
Add	Delete				
<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>				

For new providers, please send:

1) Completed provider application 2) Signed Provider Agreement 3) Copy of current credentials

CHANGE IN TAX IDENTIFICATION NUMBER (TIN) (IMPORTANT: You must submit Form W 9 with ALL "Change in TIN requests.)	
Current TIN	New TIN
Payable to Name (New TIN)	

CHANGE OF ADDRESS/ ADDING ADDRESS (*IMPORTANT: If there is a change of ownership, please submit either the bill of sale or a letter from the previous owner. Please submit page 5 of the provider application to have complete details of the office.)

OLD Physical Location Address (Street)	(Suite)	(City)	(State)	(Zip Code)
OLD Mailing Address if different (Street or PO Box)	(Suite)	(City)	(State)	(Zip Code)
OLD Payment Address if different (Street or PO Box)	(Suite)	(City)	(State)	(Zip Code)
OLD Phone Number	OLD Fax Number			
NEW/ADDING Physical Location Address (Street)	(Suite)	(City)	(State)	(Zip Code)
NEW Mailing Address if different (Street or PO Box)	(Suite)	(City)	(State)	(Zip Code)
NEW Payment Address if different (Street or PO Box)	(Suite)	(City)	(State)	(Zip Code)
NEW Phone Number	NEW Fax Number			

Doctor's Signature: _____ Date: _____

Doctor's Name (Printed): _____

Return to: FCL DENTAL
Attn: Provider Relations
101 Parkland Boulevard Suite 301
Sugar Land TX 77478
Fax #: 281-313-7155
Email: pr@fcl dental.com