Practice Location Information For Online Provider Directory

Instructions

A. If you are responding to a directory information request from us, please enter the Case Number indicated on the letter: ____________________.

B. If you are new to Dentegra, please enter all the information requested on this form.

C. If you are currently a contracted network provider:
- Log in to (or register for) your online account. Go to My Account to review and edit your directory profile and/or attest that your directory profile is correct.
- Or, use this form to enter just the information that needs to be updated in your directory profile and/or to attest that your directory profile is correct. (Use "Find a Dentist" at dentegra.com to access and review your current directory profile.)

D. Practice location name (doing business as): ____________________

Practice location address: ____________________

City: __________ County: __________ State: ______ ZIP: ________

Practice location telephone: ____________________ Practice location fax: __________

Taxpayer Identification Number (TIN): __________ Organization NPI (Type 2): __________

Practice location NPI and type: ____________________

E. Provider name: ____________________

First name Initial Last name

Specialty: ____________________ License number: ____________________

Provider's NPI (Type 1): ____________________ ☐ Male ☐ Female

F. Dental school #1: ____________________ Graduation year: __________

Dental school #2: ____________________ Graduation year: __________

G. Type of practice:

☐ Solo ☐ Clinic ☐ Dental school ☐ Mobile clinic ☐ Tribal clinic ☐ ECP ☐ FQHC

☐ Group practice ☐ Community clinic ☐ Other ____________________

5. Practice location Internet access: ☐ Yes ☐ No

Practice location website address: ____________________

Practice location email: ____________________ Directory email: ____________________

6. Special services provided at this location (please check all that apply):

☐ Accessible by public transit ☐ Treats special needs adults ☐ Treats children

☐ Early morning appointments (before 9 am) ☐ Treats special needs children ☐ Free parking

☐ Evening appointments (after 5 pm) ☐ WiFi in waiting room

7. Office hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

(Continued)

8. Wheelchair accessibility:
   Your office can be listed as accessible to persons who use wheelchairs if it meets certain "functional accessibility guidelines." Please indicate whether your office meets each of these guidelines:

   A. Doorways and entrances to the building and office are at least 32″ wide. ☐ Yes ☐ No
   B. Hallways are at least 36″ wide, with sufficient room for a wheelchair to make necessary turns. ☐ Yes ☐ No
   C. There is enough room for a wheelchair user to travel from the waiting area to the treatment area. ☐ Yes ☐ No
   D. The restroom has an accessible doorway, at least 48″ of clear floor space, and grab bars to allow transfer to/from a wheelchair. ☐ Yes ☐ No
   E. The building or office is accessible by more than stairs or a steep slope. ☐ Yes ☐ No
   F. If the building has parking facilities, there are parking spaces reserved for people with disabilities. ☐ Yes ☐ No

9. Languages spoken other than English by medical interpreter office staff:
   Provider ☐ Staff Language(s) spoken: ______________________________
   Provider ☐ Staff Language(s) spoken: ______________________________

Compliance with state and federal regulations requires Dentegra to periodically verify the accuracy of provider information in our directories. Please provide your contact information in case we need to clarify any statements or data before updating our online provider directory.

Practice location name: ______________________ Address: ______________________________

City: ______________________________ State: ____________ ZIP: ________________

Contact person's name:	Practice manager:
Telephone number: ( )	Telephone number: ( )
Email:	Email:

☐ I am new to Dentegra. My practice information is indicated on this form.

☐ I am currently contracted with Dentegra. Update my directory listing as indicated on this form.

☐ I attest that my practice information is accurate in Dentegra's online directory. No changes are necessary.

☐ I attest that the provider(s) listed below no longer treat patients nor submit claims from this location as of the date indicated.

(Dentegra will inactivate the network status at ths location for providers listed below. If necessary, use an additional sheet of paper to list more providers. Please don't use this form to add new providers.)

Providers no longer at this location (first and last names)	License number	Date

By signing below, I attest that the information entered on this form is correct.

______________________ ______________________ ______________

Print name and title Signature Date

Please return this form to us in one of these ways:
Scan and email to:
· In California: CAproviderdirectory@dentegra.com
· All other regions: providerdirectory@dentegra.com
Fax to: 916-858-4826
Mail to: Dentegra Insurance Company
Attn: Contracting and Administration
P.O. Box 1850
Alpharetta, GA 30023-1850

Copyright © 2016 Dentegra. All rights reserved.
#99700 (rev. 8/16)