NEW ASSOCIATE JOINING PRACTICE

Facility Name: _____

Tax Identification Number: _____

Phone: _____ Fax: _____ Office Email: _____

Effective ____/_____/_____, the provider below will join our practice as an associate.

Name of Provider _____

License Number: _____ Provider's NPI: _____ Email: _____

Participation Status: PPO _____ Premier _____

Please list ALL locations associated with the above Tax ID for this provider. Attach additional sheets if necessary. Please indicate whether the location (s) will be a primary location, or a fill in location for this dentist.

Service Office Address: _____ ☐ Primary ☐ Fill In

Service Office Address: _____ ☐ Primary ☐ Fill In

Service Office Address: _____ ☐ Primary ☐ Fill In

Service Office Address: _____ ☐ Primary ☐ Fill In

Service Office Address: _____ ☐ Primary ☐ Fill In

Name of person completing form: _____

Date Completed: _____/____/____

PLEASE NOTE:
If provider above is not currently a Participating Dentist with Delta Dental of AR, please contact the Professional Relations Department @ 501-992-1710
Dentist who are indicated as fill in dentist for a specific location will not be listed on our Dentist Directory. This will not affect participation in our network.
Submitting claims with this provider as the treating dentist prior to confirmation of update may result in payments made directly to our members.

Delta Dental of Arkansas
PO Box 15965
North Little Rock, AR 72231

Telephone: 1-800-462-5410
Fax: 501-992-1867