DELTA DENTAL®

Practice Location Information For Online Dentist Directory

Instructions

1. If you are responding to a directory information request from us, please enter the Case Number indicated on the letter: _____.
2. If you are new to Delta Dental, please enter all the information requested on this form and submit all pages.
3. If you are currently a contracted network dentist:
   - Review and edit your directory profile and/or attest that your directory profile is correct:
     a. Register for Provider Tools: **https://www.deltadentalins.com/RSO/shared/registration_step1.jsp**
     b. Log in to your online account: **https://www.deltadentalins.com/dentists/**
   - 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 deltadentalins.com to access and review your current directory profile.)
4. 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 Organization Subpart NPI (If applicable): _____
5. Dentist name: _____
   First name Initial Last name
   Specialty: _____ License number: _____ State(s): _____
6. Dentist's NPI (Type 1): _____ ☐ Male ☐ Female
7. Dental school #1: _____ Graduation year: _____
   Dental school #2: _____ Graduation year: _____
8. Type of practice:
   ☐ Solo ☐ Clinic ☐ Dental School ☐ Mobile clinic ☐ Essential Community Provider (ECP)
   ☐ Federally Qualified Health Clinic (FQHC) ☐ Group Practice ☐ Tribal Clinic ☐ Other _____
9. Office internet access (available to public): ☐ Yes ☐ No
   Practice location website address: _____
   Directory email (the official business email address): _____
   Practice location email: _____
   Note: The practice location email is not for public display. It's primary use is for Delta Dental to communicate with the practice location.
10. 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)
11. Accepting new patients: ☐ Yes ☐ No
12. Office hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

13. 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

14. Has your dental office completed Cultural Competency Training? ☐ Yes ☐ No
15. Languages spoken other than English:

    Dentist's language(s) other than English: _____

    Official medical interpreter language(s) other than English: _____

    Language(s) spoken by staff other than English: _____

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

Practice location name: _____ Address: _____

City: _____ State: _____ ZIP: _____

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

☐ I am new to Delta Dental. My practice information is indicated on this form. (Please include your signed Contract Agreement packet.)

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

☐ I reviewed my online directory entry at deltadentalins.com and attest that my practice information is accurate in Delta Dental's online directory. No changes are necessary.

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

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

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

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

_____ _____ _____

Print name and title | Signature | Date

Please return this form by email or fax:

California:

- **Scan and email to: CAProviderDirectory@delta.org**
- Or, fax to: 916-858-4826

All other regions:

- **Scan and email to: Pdirectory2@delta.org**
- Or, fax to:
  - Delta Dental Insurance Company (AL, FL, GA, LA, MS, MT, NV, TX, UT) — 770-641-5395
  - Delta Dental of Pennsylvania (DC, DE, MD, NY, PA, WV) — 717-774-1770

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