Notice of Sale of Practice

This is to notify Delta Dental that, pursuant to an agreement,

SELLER

Name ______________________ License number ______________________

Name of practice ______________________ Social Security number ______________________

Address of practice ______________________ (street) TIN ______________________

____
City, State, ZIP code

Seller's signature ______________________ Date ______________________

If there is more than one seller, the above information must be provided on all seller with accompanying dated signatures for each seller (you may use the back of this form).

has sold the above practice to:

PURCHASER

Name ______________________ (print or type) License number ______________________

Social Security number ______________________ TIN ______________________

Purchaser's signature ______________________ Date: ______________________

If there are two or more purchasers, the above information must be provided on all purchasers with accompanying dated signatures for each purchaser (you may use the back of this form).

Please note that if you are adding a new provider or owner that a new provider agreement must also be submitted. To request a new agreement, go to www.deltadentalins.com

I (seller) understand that, pursuant to the foregoing sale, and in accordance with my Participating Dentist Agreement with Delta Dental, all payments made by Delta Dental for Attending Dentist's Statements submitted by me, **for services dated on or before** ______________________ (date of sale) **will be issued in my name** and that, as required by law, said payments will be reported by Delta Dental to the Internal Revenue Service as my earnings. ____________ (initials)

I (purchaser) understand that Attending Dentist's Statements for services provided **after**______________________(date of sale), must be submitted under my name and will be payable to me, according to my Participating Dentist Agreement with Delta Dental, or if I do not have a Participating Dentist Agreement with Delta Dental, will be payable to the enrollee according to the terms of the enrollee's group dental care contract. ____________ (initials)

Sellers forwarding address: ______________________ (street)

____
City, State, ZIP code

Contact number for both Seller ______________________ and **Purchaser** ______________________

Reason for Sale:

- ☐ Retiring
- ☐ Maintaining participation at location under current TIN
- ☐ Working as an associate under Purchasers TIN
- ☐ Relocating to a new location
- ☐ Deceased

(continue)

Assignment of Payments

Purchaser: ______________________________
(print or type name)

Purchaser's signature: ______________________________ Date: ______________

has purchased the accounts receivable from:

Seller: ______________________________
(print or type name)

Seller's signature: ______________________________ Date: ______________

S E L L E R	Name ______________________ License number ______________ (print or type name) Name of practice ______________________ Social Security number ______________ Address of practice ______________________ TIN ______________ (street) ______________________________________ **Seller's signature** ______________________ Date ______________ Name ______________________ License number ______________ Name of practice ______________________ Social Security number ______________ Address of practice ______________________ TIN ______________ (street) ______________________________________ **Seller's signature:** ______________________ Date: ______________
P U R C H A S E R	Name ______________________ License number ______________ (print or type name) Social Security number ______________________ TIN ______________ **Purchaser's signature**______________________ Date: ______________ Name ______________________ License number ______________ Social Security number ______________________ TIN ______________ **Purchaser's signature:** ______________________ **Date:** ______________ **Please note that if you are adding a new provider or owner that a new provider agreement must also be submitted. To request a new agreement, go to www.deltadentalins.com**

Please return this form to your local Delta Dental:

Delta Dental of California
ATTN: Provider Onboarding
P.O. Box 997330
Sacramento, CA 95899-7330
Email: dentist_services@delta.org

Delta Dental Insurance Company
ATTN: Provider Onboarding
P.O. Box 1826
Alpharetta, GA 30023
Email: ProfessionalServices@delta.org

Delta Dental of Pennsylvania
ATTN: Provider Onboarding
P.O. Box 2106
Mechanicsburg, PA 17055
Email: ddpdentist_services@delta.org

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