# Delta Dental of New Jersey, Inc.
# **Service Office Location Change Form**

Phone Number: 973-285-4000 Fax Number: 973-285-4192

Please indicate the effective date of the change ____/____/____ ***Required***
**(Claims submitted from the new location with dates of service prior to the effective date may reflect non participating status. Please confirm date.)**

Dentist Name: _____ Dentist License #: _____
**(Each dentist must fill out his/her own change form. Copies are accepted.)**

OLD ADDRESS: _____

NEW ADDRESS: _____
(Physical office location of treatment.)

Phone #: _____ Fax #: _____
*****Required***** *****Required*****

Email address: _____

NEW BILLING LOCATION: _____
(Where checks are to be mailed for the above new location.)

Name for IRS Form 1099 Reporting: _____
(Must be identical to how it appears on IRS Form W-9.) *****Required*****

Tax Identification Number for IRS Form 1099 Reporting: _____
*****Required*****

To ensure our directory listings are correct, please check **(✓)**:
*****Required*****

☐ This change of address applies only to me. (I am the only dentist at this location.)

☐ This change applies to multiple dentists. (A form is required for each dentist, separately.)

Applicable Program(s):
**Please (✓) check all programs that apply:** _____ Delta Dental Premier _____ Delta Dental PPO
*****Required***** _____ Advantage Program (NJ only) _____ Non-Participating
_____ Delta Dental Patient Direct (NJ only)

I attest that the information provided in my most recent Credentialing on file at the "old office address" remains correct. I further attest that it is accurate to the new location listed above.

_____ _____
**Applicant - Print Name** **Owner - Print Name**

_____ _____
**Applicant - Signature** **Date** **Owner - Signature** **Date**

Delta Dental of New Jersey Administrative Use Only:

☐ PR Auth. _____ ☐ PR Initial/Date _____