HMSA Dental
ADDRESS CHANGE / CLOSED LOCATION / ADDITIONAL LOCATION FORM

Use this form for the following updates:

- Close an existing practice location and/or move to a new practice location
- Add a new practice affiliation not yet affiliated to
- **Required Fields are denoted with an asterisk (*). Please make sure they are filled in before submission**
- NOTE: Changes will impact all lines of business for which you are contracted.

DENTIST INFORMATION

*Dentist's Name: _____ *Degree: ☐ DDS ☐ DMD *National Provider Identifier (NPI): _____

*Dentist's Personal Email: _____ *Type of Practice: ☐ General ☐ Specialist: _____
(List Specialty type)

*Medicare Participation: ☐ Yes ☐ No *Dentist's Contact Number: _____

Please complete all section(s) that apply. If adding more than one location, please attach separate page for each location.

SECTION I: ADDRESS CHANGE

I am changing the address of an existing practice location effective (date): _____

PHYSICAL LOCATION ADDRESS

OLD location address

_____

_____

NEW location address

_____

_____

Will this be your primary location: ☐ Yes ☐ No, primary location is: _____

Will you practice at least once monthly at this location? ☐ Yes ☐ No

Appointment phone number: _____ Fax Number: _____ E-Mail Address: _____

MAILING ADDRESS *[The mailing address will also serve as your correspondence and billing address.]*

New mailing address, if changing _____

PAYMENT INFORMATION

Name of Clinic or Group Practice: _____

Billing Tax Identification Number (TIN): _____ TIN Effective Date: _____

Mail check to: ☐ Mailing/Billing ☐ Physical Address Type 1 ☐ or Type 2 ☐ NPI Number**: _____

**(Type 1 NPI for individual dentists and sole proprietors/ Type 2 NPI for incorporated dentists, group practices, clinics; limited liability companies (LLC) may have either a Type 1 or Type 2 NPI)

OTHER OFFICE INFORMATION

Languages spoken (indicate 'X' if [**D**] and/or staff [**S]**

	D	S		D	S		D	S	Other Languages – please list	D	S
Cantonese	☐	☐	Korean	☐	☐	Thai	☐	☐		☐	☐
Hawaiian	☐	☐	Mandarin	☐	☐	Tongan	☐	☐		☐	☐
Ilocano	☐	☐	Samoan	☐	☐	Vietnamese	☐	☐		☐	☐
Japanese	☐	☐	Tagalog	☐	☐				American Sign Language	☐	☐

☐ Yes ☐ No Does your office have access to interpreter services?

☐ Yes ☐ No Does your office have weeknight hours?

☐ Yes ☐ No Does your office have TDD service for patients with hearing impairments?

☐ Yes ☐ No Does your office have weekend hours?

☐ Yes ☐ No Is your office handicapped accessible?

Patient Status Indicator: ◯ Accepting New Patients ◯ Existing Patients Only

Office Contact Name: Office Contact Title:

Office Contact Number: Office Contact Email:

SECTION II: CLOSED LOCATION

I no longer practice at the following location effective (date): _____

Are claims still being filed for this affiliation? ☐ Yes ☐ No

Practice Name: _____

Street Address of closed location: _____

Forwarding Address: _____

Reason for closure of this location: _____

SECTION III: ADDITIONAL LOCATION

I am adding a new practice location effective (date): _____

PHYSICAL LOCATION ADDRESS

Address of new location: _____

_____

New mailing/billing address: _____

Will this be your primary location? ☐ Yes ☐ No, primary location is: _____

Will you practice at least once monthly at this location? ☐ Yes ☐ No

Appt. phone number: _____ Fax Number: _____ Email Address: _____

PAYMENT INFORMATION

Name of Clinic or Group Practice: _____

Billing Tax Identification Number (TIN): _____ TIN Effective Date: _____

Mail check to: ☐ Mailing/Billing ☐ Physical Address Type 1 ☐ or Type 2 ☐ NPI Number**: _____

**(Type 1 NPI for individual dentists and sole proprietors/ Type 2 NPI for incorporated dentists, group practices, clinics; limited liability companies (LLC) may have either a Type 1 or Type 2 NPI)

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Hawaiian	☐	☐	Mandarin	☐	☐	Tongan	☐	☐		☐	☐
Ilocano	☐	☐	Samoan	☐	☐	Vietnamese	☐	☐		☐	☐
Japanese	☐	☐	Tagalog	☐	☐				American Sign Language	☐	☐

☐ Yes ☐ No Does your office have access to interpreter services?

☐ Yes ☐ No Does your office have weeknight hours?

☐ Yes ☐ No Does your office have TDD service for patients with hearing impairments?

☐ Yes ☐ No Does your office have weekend hours?

☐ Yes ☐ No Is your office handicapped accessible?

Patient Status Indicator: ◯ Accepting New Patients ◯ Existing Patients Only

Office Contact Name: Office Contact Title:

Office Contact Number: Office Contact Email:

Provider/Authorized Representative Signature: _____ Date: _____

Print Name: _____