

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.

Email or Fax completed form(s) to:
 Email: HMSAdentalPR@usablelife.com
 Fax: (808) 538-8996

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	<input type="checkbox"/>	<input type="checkbox"/>	Korean	<input type="checkbox"/>	<input type="checkbox"/>	Thai	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Hawaiian	<input type="checkbox"/>	<input type="checkbox"/>	Mandarin	<input type="checkbox"/>	<input type="checkbox"/>	Tongan	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Ilocano	<input type="checkbox"/>	<input type="checkbox"/>	Samoan	<input type="checkbox"/>	<input type="checkbox"/>	Vietnamese	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Japanese	<input type="checkbox"/>	<input type="checkbox"/>	Tagalog	<input type="checkbox"/>	<input type="checkbox"/>				American Sign Language	<input type="checkbox"/>	<input type="checkbox"/>

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

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Hawaiian	<input type="checkbox"/>	<input type="checkbox"/>	Mandarin	<input type="checkbox"/>	<input type="checkbox"/>	Tongan	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Ilocano	<input type="checkbox"/>	<input type="checkbox"/>	Samoan	<input type="checkbox"/>	<input type="checkbox"/>	Vietnamese	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Japanese	<input type="checkbox"/>	<input type="checkbox"/>	Tagalog	<input type="checkbox"/>	<input type="checkbox"/>				American Sign Language	<input type="checkbox"/>	<input type="checkbox"/>

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: _____