ADDRESS CHANGE FORM

Use this form for the following updates:

- Close an existing practice location and move to a new practice location
- Update/Change the contact information related to the physical, mailing or billing address of an existing practice (i.e. street address, suite number, phone number, etc.)
- If this is a new practice, please include a current W-9 form
- **Required Fields are denoted with an asterisk (*). Please make sure they are filled in before submission**

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SECTION I: DENTAL PROVIDER INFORMATION (Non-applicable fields may be filled in with N/A or None)

Dentist's:
*Last Name _____*First_____*MI:_____Suffix: _____ *Degree: _____

*Dentist's Individual Type 1 NPI:	*Specialty:	*Dentist's Contact Number:	*Dentist's Personal Email Address:
*Medicare Participation: ☐ Yes ☐ No	*Last 4 Digits of SSN:	Secondary Languages Spoken by Provider:	

SECTION II: PRACTICE LOCATION INFORMATION (USPS valid addresses only, no P.O. boxes for physical please)

Old Practice Location Address:

*Practice Name:	*Tax ID:	*Practice NPI:
*Physical Location Address:		
*Last day worked at this address:	*Are claims still being filed for under old address? ☐ Yes ☐ No	*Reason for closure of this location:

SECTION III: INFORMATION NEEDED TO ADD NEW LOCATION (Non-applicable fields may be filled in with N/A or None)

*Working at location at least once a month? ☐ Yes ☐ No	*List this location in HMSA's directories? ☐ Yes ☐ No	*Does this change affect multiple providers? ☐ Yes ☐ No	*Effective Date of Change:
*Practice Name:		*Tax ID:	*Practice NPI:
*Physical Street Address:			
*Physical City:	*Physical State:		*Physical Zip code:
*Physical Appointment Phone Number:	*Physical Fax Number:		*Physical Email Address:
*Practice Website URL (if applicable):	*Is this your primary practice location? ☐ Yes ☐ No If no, please confirm the practice and address below:		

SECTION IV: OFFICE AND BILLING INFORMATION (Non-applicable fields may be filled in with N/A or None)

*Billing Address if different than Physical Address above:		*Billing City/State/Zip Code:	
*Mailing Address if different than Physical Address above:		*Mailing City/State/Zip Code:	
*Office Contact Name:	*Office Contact Title:	*Office Contact Phone Number:	*Office Contact Email Address:
Languages (including Sign Language) spoken by provider, staff or interpreter:			

ADDRESS CHANGE FORM

✉ : dentalproviderrelations@bshi.net 📠: (808) 538- 8996

SECTION V: ADDITIONAL OFFICE INFORMATION	
*Does your office have TDD service for patients with hearing impairments?	☐ Yes ☐ No
*Is your office accessible by public transportation?	☐ Yes ☐ No
*Is your office handicapped accessible?	☐ Yes ☐ No
*Does your office have weeknight hours?	☐ Yes ☐ No
*Does your office have weekend hours?	☐ Yes ☐ No

SECTION VI: DENTIST/AUTHORIZED REP SIGNATURE (Fields below are required to process this request)	
*Dentist's/Authorized Representative Signature:	*Date
*Printed Name:	Dentist's Social Security Number (last four digits):

Send completed forms to:

Mailing Address:	HMSA Dental Provider Relations P.O. Box 1320 Honolulu, HI 96807-1320	▪ Email: dentalproviderrelations@bshi.net ▪ Fax: (808) 538-8996

Questions regarding this form may be directed to your respective Dental Network Manager.

For general questions, please call HMSA Dental Customer Service at (808)948-6440 on Oahu and (800)792-4672 on the Neighbor islands.