CHANGE IN SPECIALTY FORM

Use this form for the following updates:

- Change/Add Dental Specialty
- If more than one specialty is kept active, you will be asked to confirm your primary, which will be applied to all of your locations displayed in HMSA's provider directories (unless you specify otherwise)
- **Required Fields are denoted with an asterisk (*). Please make sure they are filled in before submission**

hmsa

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SECTION I: DENTIST 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: SPECIALTY CHANGE INFORMATION:

*Current Dental Specialty:

*Specialty Change requested to:	*Effective date of Specialty Change:

SECTION III: Board Certification (Please attach copy of Specialty Certificate of Completion)

*Board Certified (if applicable)? ☐ Yes ☐ No

If you answered "Yes" to Board certified please provide the following information:

*Board Name:	*Specialty:	Sub-Specialty (if applicable):
*Certification Date:	*Recertification date (if applicable):	Maintenance of Certification (MOC): ☐ Yes ☐ No

SECTION IV: Professional Education and Training (Non-applicable fields may be filled in with N/A or None)

*Name of dental/professional school:		
*Address of dental/professional school:		
*Specialty:	☐ Internship ☐ Residency ☐ Fellowship	
*Specialty Training Start date:	*Specialty Training End Date:	*Date of Completion:

SECTION V: CONTACT INFORMATION (Non-applicable fields may be filled in with N/A or None)

*Office Contact Name:	*Office Contact Title:
*Office Contact Phone Number:	*Office Contact Email Address:

CHANGE IN SPECIALTY FORM

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

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, Monday – Friday, 8 am to 5pm HST, at (808)948-6440 on Oahu and (800)792-4672 on the Neighbor islands.