MULTI LOCATION CHANGE FORM – ADD/TERM AFFILIATION

Use this form for the following updates:

- Add multiple locations at one or more practices you are not yet affiliated to
- If the location being added 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: ☐ Y ☐ N	*Last 4 Digits of SSN:	Secondary Languages Spoken by Provider:	

DENTIST/AUTHORIZED REP SIGNATURE (Signature & date is 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.

Important Note: Please proceed to the next pages to fill out information regarding the affiliation changes to one or more practice locations for the dental provider listed above. If you are adding or terming an affiliation to more than (4) locations at one time for this provider, please make as many copies of the following pages as needed. All required fields are denoted with a red asterisk (*), please review and make sure all necessary fields are completed. Failure to provide complete information may extend the processing time for these changes. Thank you.

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SECTION II: ADD/TERM AFFILIATION INFORMATION (Please add info for all affected locations)

LOCATION:	***Action Requested:** ☐ ADD ☐ TERM	***If terming, provide reason:**	
***Practice Name:**		***Effective Date at location:**	
***Physical Street Address:**			
***Appt Phone:**	***Location Email Address:**		
***Fax:**	***Practice Location website URL Address:**		
***Practice NPI:**	***NPI Type:** ☐ Type 1 ☐ Type 2	***Taxpayer ID Number:**	
***Billing Address:**		***Mailing Address:**	
***Provider working at least once a month at location?** ☐ Y ☐ N		***List this location in HMSA's directories?** ☐ Y ☐ N	
***Is this your primary practice location?** ☐ Y ☐ N If N, verify primary address here:		***Is your office handicapped accessible?** ☐ Y ☐ N	
* **TDD service for patients with hearing impairments?** ☐ Y ☐ N	* **Weeknight hours?** ☐ Y ☐ N	***Weekend hours?** ☐ Y ☐ N	
***Accessible by Public transportation?** ☐ Y ☐ N	***Languages (including Sign Language) spoken by provider, staff or interpreter:**		
* **Office Contact Name:**	***Office Contact Title:**	***Office Contact Phone Email:**	***Office Contact Phone:**

LOCATION:	***Action Requested:** ☐ ADD ☐ TERM	***If terming, provide reason:**	
***Practice Name:**		***Effective Date at location:**	
***Physical Street Address:**			
***Appt Phone:**	***Location Email Address:**		
***Fax:**	***Practice Location website URL Address:**		
***Practice NPI:**	***NPI Type:** ☐ Type 1 ☐ Type	***Taxpayer ID Number:**	
***Billing Address:**		***Mailing Address:**	
***Provider working at least once a month at location?** ☐ Y ☐ N		***List this location in HMSA's directories?** ☐ Y ☐ N	
***Is this your primary practice location?** ☐ Y ☐ N If N, verify primary address here:		***Is your office handicapped accessible?** ☐ Y ☐ N	
* **TDD service for patients with hearing impairments?** ☐ Y ☐ N	* **Weeknight hours?** ☐ Y ☐ N	***Weekend hours?** ☐ Y ☐ N	
***Accessible by Public transportation?** ☐ Y ☐ N	***Languages (including Sign Language) spoken by provider, staff or interpreter:**		
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