Provider address add/change/term form

GEHA Connection Dental Network.

Please include a page of your current fee schedule

Instructions: *Copy this form for additional locations. [ ] Check here if this is an additional page.*
Return completed form(s) to: ***CDact@geha.com***

Person completing this form (IF DIFFERENT THAN PROVIDER)	First name:	Last name:
Contact email:		Phone:

General information PLEASE COMPLETE EACH SECTION IN BLACK INK. IF A QUESTION IS NOT APPLICABLE, WRITE "N/A." ALL SECTIONS MUST BE COMPLETED

Last name:	First name:	MI:	Suffix:
Other names known by:		Degrees: DDS ☐ DMD ☐ BDS ☐ MD ☐ Other ☐	
Social Security Number:	Male ☐ Female ☐	Date of birth:	
NPI 1 (Individual):	Languages other than English spoken by dentist:		

License and identification numbers PLEASE LIST ALL STATE LICENSES YOU HAVE HELD, CURRENT DEA and SDC *IF NONE, CONSIDERED WAIVERED

License and identification numbers (attach additional pages if necessary)

State	License number	License status		Federal DEA number	DEA Exp (MM/YY)			State Drug Certificate number	SDC status		
		Active	Inactive		Active - Exp Date MM/YY	In Process MM/YY	*No DEA		Active	Inactive	N/A

*By selecting 'No DEA' I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to for another practitioner for evaluation and management.

**Term date refers to when the Dr's left the practice or when Dr stopped providing dental services at location the actual term.

Practice details **Add this location** ☐ **Update this Location** ☐ **Term Location** ☐ **Term Date**** ☐

Office name:	**Term Reason:**
Phone number: Fax Number:	Start Date:
Physical address: Suite number: City: State: ZIP:	
Office Manager name:	Office manager email:
Patient directory email:	Credentialing email:
Tax ID name:	Tax ID: NPI 2 (organization):
Is this location an Essential Community Provider? Yes ☐ No ☐	Indian Health Services location? Yes ☐ No ☐

Office Hours Full Time ___ Part Time___	Monday ____ to ____	Tuesday ____ to ____	Wednesday ____ to ____	Thursday ____ to ____	Friday ____ to ____	Saturday ____ to ____	Sunday ____ to ____

Complete these fields if different from physical address

Billing or remit address			Mailing address		
Billing city	Billing state	Zip	Billing city	Billing state	Zip

Office services

Accepts new patients	Yes ☐ No ☐	Evening hours?	Yes ☐ No ☐
Medicare patients?	Yes ☐ No ☐	Include in Directory:	Yes ☐ No ☐
Medicaid patients?	Yes ☐ No ☐	Does this location offer Teledentistry:	Yes ☐ No ☐
Are there any changes that affect your availability to patients?	Yes ☐ No ☐	If yes, what platform is utilized?	
Same-day appointments?	Yes ☐ No ☐	What form of Teledentistry is performed? Asynchronous – Store & Forward Indirect Conference ☐ Synchronous – Live Audio/ Video Conference ☐	
Difficult to schedule new patients?	Yes ☐ No ☐		
24/7 coverage?	Yes ☐ No ☐	Do you provide dental services via Mobile Dentistry	Yes ☐ No ☐
Patient age limit?	Minimum age: Maximum age:	If yes, what city & state is the Mobile Dentistry provided?	
Weekend hours?	Yes ☐ No ☐	What services do you perform via the Mobile Dentistry? Diagnostic ☐ Preventative ☐ Restorative ☐ Other ☐	
Languages spoken by staff, other than English:		Where is the Mobile Dentistry service performed? Mobile Dentistry Vehicle ☐ Off site patient/customer location ☐	
Is the location handicap accessible? Yes ☐ No ☐			