

# Provider address add/change/term form



## Submission Instructions:

- Please attach a copy of the fee schedule for your office.
- Return completed form(s) to: CDact@geha.com
- Allow 14 business days for processing.
- For Follow-Ups: Email to: [connection.dentalweb@geha.com](mailto:connection.dentalweb@geha.com) or call 800-505-8880 opt 3

Person completing this form (IF DIFFERENT THAN PROVIDER)		First name:	Last name:
Phone number:		Completed by provider/office manager: Yes <input type="checkbox"/> No <input type="checkbox"/>	
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 <input type="checkbox"/> DMD <input type="checkbox"/> BDS <input type="checkbox"/> MD <input type="checkbox"/> Other <input type="checkbox"/>	
Social Security number:		Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth:
NPI 1 (Individual):		Languages other than English spoken by dentist:	

Required provider/office manager signature:

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

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 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 <input type="checkbox"/>	Update this location <input type="checkbox"/>	Term location <input type="checkbox"/>	Term date* <input type="checkbox"/>			
Office name:	Term reason:						
Phone number:	Fax number: Start date:						
Physical address:	Suite number:		City:		State:		ZIP:
Location email:							
Office only email:	Credentialing email:						
Tax ID name:	Tax ID:				NPI 2 (organization):		
Is this location an Essential Community Provider? Yes <input type="checkbox"/> No <input type="checkbox"/>	Indian Health Services location? Yes <input type="checkbox"/> No <input type="checkbox"/>						
Office hours Full time <input type="checkbox"/> Part time <input type="checkbox"/>	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	Mailing city	Mailing state	Zip			
Office services								
Accepts new patients?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Evening hours?			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Accepts Medicare patients?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Include in Directory:			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Accepts Medicaid patients?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Does this location offer Teledentistry:			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Are there any changes that affect your availability to patients?	Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, what platform is utilized?					
Are you able to schedule routine appointments within 30 days of request?	Yes <input type="checkbox"/> No <input type="checkbox"/>		What form of Teledentistry is performed?					
Same-day appointments?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Asynchronous – Store & <input type="checkbox"/>				Synchronous – Live Audio/ <input type="checkbox"/>	
Difficult to schedule new patients?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Forward Indirect Conference				Video Conference	
24/7 coverage?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you provide dental services via Mobile Dentistry Yes <input type="checkbox"/> No <input type="checkbox"/>					
Patient age limit?	Minimum age: _____ Maximum age: _____		If yes, what city & state is the Mobile Dentistry provided?					
Weekend hours?	Yes <input type="checkbox"/> No <input type="checkbox"/>		What services do you perform via the Mobile Dentistry?					
Diagnostic <input type="checkbox"/> Preventative <input type="checkbox"/> Restorative <input type="checkbox"/> Other <input type="checkbox"/>								
Languages spoken by staff, other than English:								
Where is the Mobile Dentistry service performed?								
Mobile Dentistry Vehicle <input type="checkbox"/> Off site patient/customer location <input type="checkbox"/>								
Is the location handicap accessible? Yes <input type="checkbox"/> No <input type="checkbox"/>								