Provider address add/change/term form

GEHA Connection Dental Network.

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 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 ☐ No ☐	Completed by consultant: Yes ☐ No ☐

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:			
Required provider/office manager signature:				

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:
Location email:				
Office only 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	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	___ to ___	___ to ___	___ to ___	___ to ___	___ to ___	___ to ___	___ 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 ☐ No ☐	Evening hours?	Yes ☐ No ☐
Accepts Medicare patients?	Yes ☐ No ☐	Include in Directory:	Yes ☐ No ☐
Accepts 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?	
Are you able to schedule routine appointments within 30 days of request?	Yes ☐ No ☐	What form of Teledentistry is performed? Asynchronous – Store & Forward Indirect Conference ☐ Synchronous – Live Audio/ Video Conference ☐	
Same-day appointments?	Yes ☐ No ☐		
Difficult to schedule new patients?	Yes ☐ No ☐	Do you provide dental services via Mobile Dentistry	Yes ☐ No ☐
24/7 coverage?	Yes ☐ No ☐	If yes, what city & state is the Mobile Dentistry provided?	
Patient age limit?	Minimum age: Maximum age:	What services do you perform via the Mobile Dentistry?	
Weekend hours?	Yes ☐ No ☐	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 ☐			