

Practice Location Information For Online Dentist Directory

1. If you are responding to a directory information request from us, please enter the case number indicated on the letter: _____.
2. If you are new to Delta Dental, please enter all the information requested on this form and submit all pages.
3. If you are currently a contracted network dentist, review and edit your directory profile and/or attest your directory profile is correct.
 - a. Register for Provider Tools:
https://www.deltadentalins.com/RSO/shared/registration_step1.jsp
 - b. Log in to your online account: **<https://www.deltadentalins.com/dentists/>**
 - c. Or, use this form to enter just the information that needs to be updated in your directory profile and/or to attest your directory profile is correct. (Use “Find a Dentist” at **[deltadentalins.com](https://www.deltadentalins.com)** to access and review your current directory profile.)

4. Practice location name (doing business as): _____
Practice location address: _____
City: _____ County: _____ State: _____ ZIP: _____
Practice location telephone: _____ Practice location fax: _____
Taxpayer Identification Number (TIN): _____
Organization NPI (Type 2): _____

5. Type of practice:
 Solo Clinic Dental School Mobile clinic
 Essential Community Provider (ECP) Federally Qualified Health Clinic (FQHC)
 Group Practice Tribal Clinic Other: _____

6. Office internet access (available to public): Yes No
Practice location website address: _____
Directory email (the official business email address): _____
Practice location email: _____

Note: The practice location email is not for public display. Its primary use is for Delta Dental to communicate with the practice location.

7. Special services provided at this location (please check all that apply):

<input type="checkbox"/> Early morning appointments (Before 9:00am)	<input type="checkbox"/> Evening appointments (after 5:00pm)
<input type="checkbox"/> Accessible by public transit	<input type="checkbox"/> Treats children with physical disabilities
<input type="checkbox"/> Treats children	<input type="checkbox"/> Treats adults with physical disabilities
<input type="checkbox"/> Free parking	<input type="checkbox"/> Telehealth Services

Questions 7a through 7g are to be filled out when you are enrolling for DCUSA only. If you are not enrolling in DCUSA, please skip these questions and move to Question 8:

- a. Number of Operatories: _____

- b. Does this facility offer IV sedation? Yes No
- c. Does this facility offer amalgam restorations? Yes No
- d. Does this facility offer general anesthesia? Yes No
- e. Does this facility offer nitrous oxide? Yes No
- f. Does this facility have on-site laboratory? Yes No
If yes, Complete Limited
- g. Does this facility offer panoramic x-rays? Yes No

8. Office hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

9. Wheelchair accessibility: Your office can be listed as accessible to persons who use wheelchairs if it meets certain “functional accessibility guidelines.” Please indicate whether your office meets each of these guidelines:

- a. Doorways and entrances to the building and office are at least 32” wide. Yes No
- b. Hallways are at least 36” wide, with sufficient room for a wheelchair to make necessary turns. Yes No
- c. There is enough room for a wheelchair user to travel from the waiting area to the treatment area. Yes No
- d. The restroom has an accessible doorway, at least 48” of clear floor space, and grab bars to allow transfer to/from a wheelchair. Yes No
- e. The building or office is accessible by more than stairs or a steep slope. Yes No
- f. If the building has parking facilities, there are parking spaces reserved for people with disabilities. Yes No

10. Has your dental office completed Cultural Competency Training? Yes No

11. Is this office accepting new patients for DeltaCare USA Plans? Yes No

12. Language(s) spoken by staff other than English: _____

13. Dentist Information.

If necessary, use an additional sheet of paper to list more dentists.

A Dentist name: First name: _____ Initial: ___ Last name: _____
 Specialty: _____ License number: _____ State(s): _____
 Dentist’s NPI (Type 1): _____ Male Female
 Dentist’s preferred pronouns: He/Him She/Her They/Them
 Dentist’s Country of birth: United States Other: _____
 Dentist’s language(s) other than English: _____
 Official medical interpreter language(s) other than English: _____
 Does this dentist have hospital privileges? Yes No
 Accepting new patients for PPO/Premier Plans: Yes No
 Services rendered by this provider:
 Treats children
 Treats children with intellectual disabilities
 Treats adults with intellectual disabilities

B Dentist name: First name: _____ Initial: ___ Last name: _____
 Specialty: _____ License number: _____ State(s): _____
 Dentist's NPI (Type 1): _____ Male Female
 Dentist's preferred pronouns: He/Him She/Her They/Them
 Dentist's Country of birth: United States Other: _____
 Dentist's language(s) other than English: _____
 Official medical interpreter language(s) other than English: _____
 Does this dentist have hospital privileges? Yes No
 Accepting new patients for PPO/Premier Plans: Yes No
 Services rendered by this provider:
 Treats children
 Treats children with intellectual disabilities
 Treats adults with intellectual disabilities

C Dentist name: First name: _____ Initial: ___ Last name: _____
 Specialty: _____ License number: _____ State(s): _____
 Dentist's NPI (Type 1): _____ Male Female
 Dentist's preferred pronouns: He/Him She/Her They/Them
 Dentist's Country of birth: United States Other: _____
 Dentist's language(s) other than English: _____
 Official medical interpreter language(s) other than English: _____
 Does this dentist have hospital privileges? Yes No
 Accepting new patients for PPO/Premier Plans: Yes No
 Services rendered by this provider:
 Treats children
 Treats children with intellectual disabilities
 Treats adults with intellectual disabilities

Compliance with state and federal regulations requires Delta Dental to periodically verify the accuracy of dentist information in our directories. Please provide your contact information in case we need to clarify any statements or data before updating our online dentist directory.

Practice location name: _____ Address: _____
 City: _____ State: _____ ZIP: _____

Contact person's name:	Practice manager:
Telephone number: ()	Telephone number: ()
Email:	Email:

- I am new to Delta Dental. My practice information is indicated on this form. (Please include your signed Contract Agreement packet.)
- I am currently contracted with Delta Dental. Update my directory listing as indicated on this form.
- I reviewed my online directory entry at **deltadentalins.com** and attest that my practice information is accurate in Delta Dental's online directory. No changes are necessary.
- I attest that the dentist(s) listed below no longer treat patients nor submit claims from this location as of the date indicated

