DELTA DENTAL®

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** 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. It's primary use is for Delta Dental to communicate with the practice location.
7. Special services provided at this location (please check all that apply):
   a. Services provided at this location:
      ☐ Early morning appointments (Before 9:00am)
      ☐ Accessible by public transit
      ☐ Treats children
      ☐ Free parking
      ☐ Evening appointments (after 5:00pm)
      ☐ Treats children with physical disabilities
      ☐ Treats adults with physical disabilities

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. 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
Dental school #1: _____ Graduation year (MM/YYYY): _____
Dental school #2: _____ Graduation year (MM/YYYY): _____
Languages spoken other than English:
Dentist's language(s) other than English: _____
Official medical interpreter language(s) other than English: _____
Language(s) spoken by staff other than English: _____
Services rendered by this provider: Accepting new patients: ☐ Yes ☐ No
☐ 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
Dental school #1: _____ Graduation year (MM/YYYY): _____
Dental school #2: _____ Graduation year (MM/YYYY): _____
Languages spoken other than English:
Dentist's language(s) other than English: _____
Official medical interpreter language(s) other than English: _____
Language(s) spoken by staff other than English: _____
Services rendered by this provider: Accepting new patients: ☐ Yes ☐ No
☐ 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
Dental school #1: _____ Graduation year (MM/YYYY): _____
Dental school #2: _____ Graduation year (MM/YYYY): _____
Languages spoken other than English:
Dentist's language(s) other than English: _____
Official medical interpreter language(s) other than English: _____
Language(s) spoken by staff other than English: _____

Services rendered by this provider:
☐ Treats children,
☐ Treats children with intellectual disabilities,
☐ Treats adults with intellectual disabilities

Accepting new patients: ☐ Yes ☐ No

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

Dentists no longer at this location (first and last names)	License number	Date

(Delta Dental will inactivate the network status at the location for dentists listed above. If necessary, use an additional sheet of paper to list more dentists. Please don't use this form to add new dentists.)

By signing below, I attest I am authorized to represent the information entered on this form is correct.

Print name and title _____ Signature _____ Date _____

California: Scan and email to **CAProviderDirectory@delta.org**

All other regions: Scan and email to **provider_directory@delta.org**

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