



Notice of Sale of Practice

This is to notify Delta Dental that, pursuant to an agreement,

S E L L E R	Name _____	License number _____
	Name of practice _____	Social Security number _____
	Address of practice _____ <small>(street)</small>	TIN _____
	City, State, ZIP code _____	
	Seller's signature _____	Date _____

If there is more than one seller, the above information must be provided on all seller with accompanying dated signatures for each seller (you may use the back of this form).

has sold the above practice to:

P U R C H A S E R	Name _____ <small>(print or type)</small>	License number _____
	Social Security number _____	TIN _____
	Purchaser's signature _____	Date: _____
	If there are two or more purchasers, the above information must be provided on all purchasers with accompanying dated signatures for each purchaser (you may use the back of this form).	
	Please note that if you are adding a new provider or owner that a new provider agreement must also be submitted. To request a new agreement, go to www.deltadentalins.com	

I (seller) understand that, pursuant to the foregoing sale, and in accordance with my Participating Dentist Agreement with Delta Dental, all payments made by Delta Dental for Attending Dentist's Statements submitted by me, **for services dated on or before** _____ (date of sale) **will be issued in my name** and that, as required by law, said payments will be reported by Delta Dental to the Internal Revenue Service as my earnings. _____
(initials)

I (purchaser) understand that Attending Dentist's Statements for services provided **after** _____ (date of sale), must be submitted under my name and will be payable to me, according to my Participating Dentist Agreement with Delta Dental, or if I do not have a Participating Dentist Agreement with Delta Dental, will be payable to the enrollee according to the terms of the enrollee's group dental care contract. _____
(initials)

Sellers forwarding address: _____
(street)

City, State, ZIP code

Contact number for both Seller _____ **and Purchaser** _____

Reason for Sale:

- Retiring
- Maintaining participation at location under current TIN
- Working as an associate under Purchasers TIN
- Relocating to a new location
- Deceased

(continue)

Assignment of Payments

Purchaser: _____
(print or type name)

Purchaser's signature: _____ **Date:** _____

has purchased the accounts receivable from:

Seller: _____
(print or type name)

Seller's signature: _____ **Date:** _____

S E L L E R	Name _____ <small>(print or type name)</small>	License number _____
	Name of practice _____	Social Security number _____
	Address of practice _____ <small>(street)</small>	TIN _____
	Seller's signature _____	Date _____
	Name _____	License number _____
	Name of practice _____	Social Security number _____
P U R C H A S E R	Address of practice _____ <small>(street)</small>	TIN _____
	Seller's signature: _____	Date: _____
	Name _____ <small>(print or type name)</small>	License number _____
	Social Security number _____	TIN _____
	Purchaser's signature _____	Date: _____
	Name _____	License number _____
Social Security number _____	TIN _____	
Purchaser's signature: _____	Date: _____	
<p>Please note that if you are adding a new provider or owner that a new provider agreement must also be submitted. To request a new agreement, go to www.deltadentalins.com</p>		

Please return this form to your local Delta Dental:

Delta Dental of California
 ATTN: Provider Data Management
 P.O. Box 997330
 Sacramento, CA 95899-7330
Email: dentist_services@delta.org

Delta Dental Insurance Company
 ATTN: Provider Data Management
 P.O. Box 1826
 Alpharetta, GA 30023
Email: ProfessionalServices@
 ddic.delta.org

Delta Dental of Pennsylvania
 ATTN: Provider Data Management
 P.O. Box 2106
 Mechanicsburg, PA 17055
Email: ddpdentist_services@
 deltadentalpa.org