



## Dental Office Change Request Form

If your request is to change your provider’s information, please refer to the **Provider change form**. The Dental Office Change Request form is to be used for all changes related to an office address and applies to all current providers listed at the office. Form must be signed and dated in order to be considered complete, if any information is missing, we will contact your office for additional information. \*Submit a signed/dated W9 where the (\*) indicates.

### SECTION I OFFICE INFORMATION:

TIN: \_\_\_\_\_ IRS Name: \_\_\_\_\_  
*(Tax Identification Number used when submitting claims) (Name as registered with the IRS)*

Office Name: \_\_\_\_\_  
*(Doing Business As, if different than IRS name, please indicate)*

Office Address: \_\_\_\_\_  
*(Address, bldg., ste #, City, ST, Zip) Address listed here must be used when submitting a claim*

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Email: \_\_\_\_\_

### Please Indicate Change(s) Below:

**TIN Change - New TIN:** \_\_\_\_\_ Effective Date of new TIN: \_\_\_\_\_  
*(Attach a current \*W9 signed and dated)*

**Office Change – What is changing?**  
 IRS Name *(attach a current \*W9 signed and dated)*  Office Name  Phone/Fax/Email/N PI/Other

New Office Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Web Address: \_\_\_\_\_

Clinic NPI: \_\_\_\_\_ Corporate NPI: \_\_\_\_\_  
*(Please provide your entity type 2 NPI)*

**Address Change – Which Address is changing?** *(Please complete full address, city, state and zip)*  
 Office Address  Billing Address  Correspondence Address

New Office Address: \_\_\_\_\_  
*(Address, bldg., ste #, City, ST, Zip) - Address listed here must be used when submitting a claim*

New Billing Address: \_\_\_\_\_  
*(Address, bldg., ste #, City, ST, Zip)*

New Correspondence Address: \_\_\_\_\_  
*(Address, bldg., ste #, City, ST, Zip)*

Effective Date of new address: \_\_\_\_\_

Horizon Blue Cross Blue Shield of New Jersey is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross and Blue Shield Association. The Horizon® name, and symbols are registered marks of Horizon Blue Cross Blue Shield of New Jersey. © 2013 Horizon Blue Cross Blue Shield of New Jersey - Three Penn Plaza East, Newark, New Jersey 0710

Other (please indicate change to clinic): \_\_\_\_\_

If a new location, please indicate the network provider desired:

No Change or  Traditional/DOP  PPO  FEP  1262\*  HDC\*

For your convenience, we have provided you with a mail to address. Please sign, date and return the form to one of the contacts below:

**Mail To:** Horizon Blue Cross Blue Shield of NJ Dental Programs  
**Attn: Dental Services Manager**  
3 Penn Plaza East PP-13Y  
Newark, NJ 07105  
Fax: (973) 274-2202

By signing this form, you are an authorized signee on behalf of the practice and attest that the information contained in this form is accurate and correct. ***Form must be signed and dated on unique lines in order to process any of the requested changes.***

Signature: \_\_\_\_\_ Please Print: \_\_\_\_\_

Date: \_\_\_\_\_

\*These Networks may be subject to approval