

## Change in Dental Provider Information

INSTRUCTIONS		
<p><b>IMPORTANT:</b> You must complete the general information and authorized signature sections to ensure processing is complete. Submit form to:</p> <ul style="list-style-type: none"> <li>■ CareFirst BlueCross BlueShield and CareFirst BlueChoice Dental Provider Networks and Credentialing—Mailstop RRS-130 10455 Mill Run Circle, Owings Mills, MD 21117</li> <li>■ Fax 410-720-5080</li> <li>■ Email <a href="mailto:dentalcontracting@carefirst.com">dentalcontracting@carefirst.com</a></li> </ul>		
GENERAL INFORMATION		
Effective Date of Change	Name of Person Authorized to Make Change	Telephone #
Practice/Provider Name		Tax ID #
ADDRESS CHANGE		
<p>This field should only be used if moving to another location or making corrections. Please submit a letter of explanation, a completed Dental Billing Authorization Form and W-9 form to CareFirst BlueCross BlueShield (CareFirst), The Dental Network or CareFirst BlueChoice.</p>		
Current Address		
New Address		
PHONE # CHANGE		
Current Telephone #	New Telephone #	
TAX ID CHANGE		
<p>Attach <b>Dental Billing Authorization Form</b> (found at <a href="http://carefirst.com/providerforms">carefirst.com/providerforms</a>) and W-9 form.</p>		
Current Tax ID #	New Tax ID #	
NAME CHANGE		
<p>For an individual name change, attach a copy of marriage license, divorce decree, or other documentation.</p>		
Current Name	New Name	
PROVIDER LEAVING PRACTICE		
Name	Reason for Leaving	
	Leaving Practice	Retiring      Deceased
PRACTICE SALE		
Attach bill of sale		
Seller's Tax ID	Seller's Practice Name	
Buyer's Name	Date of Sale	
AUTHORIZED SIGNATURE		
By signing below, you authorize CareFirst and/or CareFirst BlueChoice to make the indicated changes.		
Signature	Title	Date