# Provider Information Demographic Change Submission Form

United Healthcare | Dental Benefit Providers

**Description of when to use form:** To be used by provider if the provider has made changes to ANY of their demographic information (name change, address change, TIN change, etc.). *Form must be signed at bottom to be processed. Please list all providers associated with this change. Failure to sign, list all associated providers requesting the update, or attach required documentation will delay your request.*

**Providers:** To ensure your claims are processed correctly and on a timely basis, if you have had any changes to your demographic information, please ensure you submit your demographic changes **PRIOR** to submitting your claim(s) and within 30 days of the change taking place.
For real-time updates and to reduce turn around times by 3-5 days, please visit the Self Service section after registration and log-in on uhcdental.com

Please check **ALL** the demographic items that **need** to be updated and complete all sections as appropriate. Please submit completed form using one of the methods to the right:
Request Number (if given by Customer Service):_____

**Mailing Address:** Dental Benefit Providers, Inc. (DBP-CA Inc)
ATTN: Dental Provider Services
PO Box 30567, Salt Lake City UT 84130
**Fax:** 248-733-6372
**Email:** dbpprvfx@uhc.com

☐ Please check box if making a TIN (Tax ID Number) change. (***Copy of updated W-9 form is required***) ***May be subject to new contracting.***

| **Current Tax ID:** | **New Tax ID:** | **Effective date of change :** | **Reprocess Claims? :** ☐ ***Yes*** |
|---|---|---|---|

☐ Please check box if making a dentist name change. (***Copy of updated dental license is required***)

| | | |
|---|---|---|
| **Current Name:** | (Last) | (First) |
| **New Name:** | (Last) | (First) |

☐ Please check box if changing specialty. (***Copy of specialty certification is required***) ☐ Please check box if board certified.

**Effective date of office information change:** ☐ Please check if office is handicap accessible.

| **PRACTICE LOCATION** | **REMITTANCE ADDRESS** |
|---|---|
| **Previous/Current Office Name:** | **New Office Name:** |
| **Previous/Current Address:** | **Previous/Current Address:** |
| (Street #) (Suite #) | (Street #) (Suite #) |
| (City) (State) (Zip) | (City) (State) (Zip) |
| **New Address:** | **New Address:** |
| (Street #) (Suite #) | (Street #) (Suite #) |
| (City) (State) (Zip) | (City) (State) (Zip) |

**Languages Spoken Other Than English:** ☐ Please check box if remittance is same as office location.

**Phone Number:** **Fax Number:** **Email Address:**

| **New Office Hours:** | Mon | Tue | Wed | Thu | Fri | Sat | Sun |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

☐ ***Please check box if Associate Provider(s) need to be termed*** **Term Reason:** ☐ **Provider Left Practice** ☐ **Other**

**Providers associated with the requested change:** _____

**PROVIDER SIGNATURE:** **DATE:**