



## Dental Network Provider Change Notice

Today's Date: \_\_\_\_\_

Requested By: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

Dentist Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Practicing Specialty: \_\_\_\_\_ NPI #: \_\_\_\_\_

Dental Therapist: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

NPI #: \_\_\_\_\_

Advanced Dental Therapist: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

NPI #: \_\_\_\_\_

**Note that Advanced Dental Therapists must be credentialed before they can provide care to HealthPartners members.**

**Add**    **Terminate Provider (check one)**

Effective Date: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

If this is a termination, is this provider retiring? \_\_\_\_\_

**You may fax, email or mail this form to HealthPartners Dental Contracting. Remember to submit new provider information as soon as possible to begin the credentialing process as it takes at least 30 days to complete. This form is available on the HealthPartners Provider Portal/Library/Dental Provider Information.**

HealthPartners Dental Contracting  
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