Dental provider contract information

PacificSource

The information provided on this form will be used to set up your provider, group, or facility records, as well as your contract and provider directory listing.

Dental provider

Name _____

Specialty type _____

Language fluency _____

Individual NPI _____

Tax ID number _____

Provider's patient capacity _____

Provider Medicare ID _____

Dental practice

Name _____

Group NPI _____

Group Medicare ID _____

Tax ID number _____

Please use the Group or Facility Roster form and include it with this form

Group's total patient capacity _____

Line of business requested (select all that apply)

☐ Commercial (PacificSource Health Plans)

☐ Medicare (PacificSource Community Health Plans)

Dental practice information (for patient visits and directory listing)

Practice name (as it should appear in the directory) _____

Address _____

City _____ State _____ Zip code _____ County _____

Location effective date _____ ☐ Adding location ☐ Changing location

Contact name _____ Contact email _____

Contact title _____ Practice phone _____ Practice fax _____

Do you require a separate fee for PacificSource members to access care with your providers? ☐ Yes ☐ No

Billing information

Billing name (as it appears on claims) _____

Address _____

City _____ State _____ Zip code _____ County _____

Location eff. date _____ ☐ Adding location ☐ Changing location

Billing contact name _____

Billing contact email _____

Billing contact phone _____ Billing contact fax _____

Form completed by _____ Role/title _____

Email _____ Phone _____ Date completed _____

Return this form to: DentalContracting@PacificSource.com | Fax: 541-225-3643

Questions? Email DentalContracting@PacificSource.com. We're happy to help.