HMSA Dental
ADDRESS CHANGE / CLOSED LOCATION / ADDITIONAL LOCATION FORM

NOTE: Changes will impact all lines of business for which you are contracted.

Provider Name: ____________________ Degree: DMD or DDS *(circle one)*

HMSA Provider Number: ____________________ Social Security Number: ____________________

National Provider Identifier (NPI) ____________ Type of Practice: ❐ General ❐ Specialist: ____________ *(List Specialty type)*

Indicate type of practice: ❐ Sole Proprietor* ❐ Limited Liability Co. ❐ Incorporated ❐ Other: ____________

Please complete all section(s) that apply. If adding more than one location, please attach separate page for each location.

SECTION I: ADDRESS CHANGE

I am changing the address of an existing practice location effective (date): ____________

PHYSICAL LOCATION ADDRESS

OLD location address ____________________ NEW location address ____________________

Will this be your primary location: ❐ Yes ❐ No, primary location is: ____________________

Appointment phone number: ____________ Fax Number: ____________

E-Mail Address: ____________________

MAILING ADDRESS *[The mailing address will also serve as your correspondence and billing address.]*

New mailing address, if changing ____________________

PAYMENT INFORMATION

BSH USE ONLY – STATUS OF BILLING TAX ID ❐ Par ❐ Non-Par

Name of Clinic or Group Practice: ____________________

Billing Tax Identification Number (TIN) of Clinic or Group: ____________ TIN Effective Date: ____________

Mail check to: ❐ Mailing Address ❐ Physical Address Type 1 or Type 2 NPI Number**: ____________

**(Type 1 NPI for individual dentists and sole proprietors/ Type 2 NPI for incorporated dentists, group practices, clinics; limited liability companies (LLC) may have either a Type 1 or Type 2 NPI)

OTHER OFFICE INFORMATION

Number of office staff (including provider): ________

Number of staff who speak languages other than English (including American Sign Language: ________

Languages spoken (indicate 'X' if [**P**] and/or staff [**S**]

	P	S		P	S		P	S		P	S
Cantonese	❐	❐	Korean	❐	❐	Thai	❐	❐	Other languages – please list		
Hawaiian	❐	❐	Mandarin	❐	❐	Tongan	❐	❐	____________	❐	❐
Ilocano	❐	❐	Samoan	❐	❐	Vietnamese	❐	❐	____________	❐	❐
Japanese	❐	❐	Tagalog	❐	❐	Sign Language	❐	❐			

Access to interpreter services: ❐ Yes ❐ No Accessibility for people with disabilities: ❐ Yes ❐ No

Provider Name: ____________________

SECTION II: CLOSED LOCATION

I no longer practice at the following location effective (date): ____________

HMSA location Provider Number: ____________

Street address of closed location: ____________

Forwarding address: ____________

Reason for closure of this location: ____________

SECTION III: ADDITIONAL LOCATION

I am adding a new practice location effective (date): ____________

PHYSICAL LOCATION ADDRESS

Address of new location: ____________

____

New mailing/billing address: ____________

____

Will this be your primary location? ❒ Yes ❒ No, primary location is: ____________

Appt. phone number: ____________ Fax Number: ____________ Email Address: ____________

PAYMENT INFORMATION

BSH USE ONLY – STATUS OF BILLING TAX ID
❒ **Par** ❒ **Non-Par**

Name of Clinic or Group Practice: ____________

Billing Tax Identification Number (TIN) of Clinic or Group: ____________ TIN Effective Date: ____________

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	P	S		P	S		P	S		P	S
Cantonese	❒	❒	Korean	❒	❒	Thai	❒	❒	Other languages – please list		
Hawaiian	❒	❒	Mandarin	❒	❒	Tongan	❒	❒	____________	❒	❒
Ilocano	❒	❒	Samoan	❒	❒	Vietnamese	❒	❒	____________	❒	❒
Japanese	❒	❒	Tagalog	❒	❒	Sign Language	❒	(			

Access to interpreter services: ❒ Yes ❒ No Accessibility for people with disabilities: ❒ Yes ❒ No

Provider's signature ____________________ Date: ____________

Please mail or fax this completed form to: HMSA Dental Services, P.O. Box 1320, Honolulu, HI 96807-1320. Fax: (808) 538-8996

For questions, please contact your respective Provider Relations Specialist. For general questions, please call HMSA Dental Services at (808) 948-6440 on Oahu and (800) 792-4672 on the neighbor islands.