HealthPartners

Dental Network Provider Change Notice

Today's Date: _____

Requested By: _____ Contact Email or Phone #: _____

Change For: ☐ Dentist ☐ Therapist/Advanced Dental Therapist

Last Name: _____ First Name: _____

Practicing Specialty: _____ NPI #: _____

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

Languages spoken fluently to treat patients: _____

Race and/or ethnicity: *(The following information is optional and may be used in provider directories to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.)*

Check here if you do not wish for your race and/or ethnicity to be displayed in provider directories ☐

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacifica Islander
☐ Hispanic or Latino ☐ White ☐ Other ☐ Prefer Not to Say

☐ **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
PO Box 1309
Minneapolis, MN 55440-1309
Fax: (952) 883-5160
Phone: (952) 883-6140
Email: dentalcontracting@healthpartners.com