Practice Information Update Form

Delta Dental of New Mexico

Instructions

Indicate below all current information about your practice. Please include a current IRS Form W-9 if you are making changes to the business name or address. **Note:** Practice information on this form, except for the billing tax identification number, will be visible to the public via our online provider search tools and/or provider directories.

Practice Information

Do you provide Tele Health? ☐ Y ☐ N (Answer required)

Business Name	
Street Address (including City, State, and ZIP Code)	
Telephone	**Fax**
Office Email Address	**Billing Tax Identification Number**
National Provider Identification (NPI) Number Type 2	

Office Hours

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

Sunday _____

Current Practicing Providers

Please list all providers credentialed at your service office location (to list additional providers, please attach a separate sheet):

Provider Name _____ **Provider Name** _____

Provider Name _____ **Provider Name** _____

_____ _____

Signature of the Person Submitting this Form

Name of the Person Submitting this Form (print)

_____

Date Signed

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