

Dentist Information Update Form

Please complete this form and return to Argus Dental Plan by mail: 4010 W. State St., Tampa, FL 33609, fax: 813-490-0093 or email: Provider.Relations@argusdental.com

Provider Name: _____ Current Provider/Practice TIN: _____
Practice Name: _____
Name of Individual completing this Form: _____
Telephone #: _____ Date: _____

This affects the following plans: ___ Master ___ Prime X ___ Smile Card ___ Medicaid ___ PPO

PLEASE MAKE THE FOLLOWING CHANGES TO OUR PRACTICE INFORMATION:

___ The new tax identification number is: -

___ We have changed our office name effective on this date:

We will now be called: _____

___ We have moved. Our new address is effective on this date:

Old Address:

New Address:

___ We have changed our payment address effective:

Old Address:

New Address:

___ We want to add a new location or term a location effective:

PLEASE CIRCLE ONE: ADD / TERM

Address:

___ We have added the following dentist to our practice effective:

Please send us an application package for our new physician. (Please provide a list if more than one)

___ The following provider has left our practice effective:

(Please provide a list if more than one) Please reassign members to the following office:

___ Please update the provider's website password to (case sensitive): _____

PROVIDER SIGNATURE _____

PR SIGNATURE (internal use only) _____