UnitedHealthcare
OXFORD

Today's Date ____________________

Dental Provider Information Change Form

Oxford Health Plans (CT), Inc., Oxford Health Plans (NY), Inc., Oxford Health Plans (NJ), Inc.

Mailing Address: Dental Department, 48 Monroe Turnpike, Trumbull, CT 06611 ▪ 1-800-520-1829, Option 3

I. NEW/ADDITIONAL INFORMATION

Provider Last Name, First Name: ____________________

Street Address, Suite Number: ____________________

City, State, Zip: ____________________ Fax #: ____________________

Telephone #: ____________________

ID #: ____________________ Date of Birth: ____________________

Social Security #: ____________________

License #: ____________________

Primary Care Dentist ❒ Yes E-Mail: ____________________

Specialty Care Dentist ❒ Yes If yes, specify type ____________________

Hours you practice in the office (not hours office is open) Monday __________ Tuesday __________ Wednesday __________

Thursday __________ Friday __________ Saturday __________

Sunday __________

Is your office handicap accessible? __________ Do you provide signs for vision impairments? __________

Billing Address (if different from address listed above): ____________________

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•Please include current credentials, license, DEA, CDS (NJ only), malpractice agreement.

*Please include a W9 attached to this form.