Ameritas PPO Provider Revision Form

Owner Name: ____________________________________ Confirmation Preference: ☐ Email__________________________

Business Name: _________________________________ ☐ Fax ___________________________

Tax ID #: _____________________________ ☐ Phone___________________________

☐ ADD ASSOCIATE ☐ TERM ASSOCIATE Effective Date: ________________

Associate Name: ____

Address: ____________________________________ City: ____________________ State: _____ Zip Code: ___________

Address: ____________________________________ City: ____________________ State: _____ Zip Code: ___________

Address: ____________________________________ City: ____________________ State: _____ Zip Code: ___________

***** COMPLETE BELOW SECTION FOR ADD'S ONLY *****

Title: ☐ DDS ☐ DMD Dental License #: ___________________ Individual NPI #: ___________________ Gender: ☐ M ☐ F

Specialty: ____________________ ***Note: If left blank, associate will be added as a General Dentist***

If Specialist, Board Status: ☐ Certified ☐ Eligible – Indicate highest level of education ___________________________

☐ ADD ASSOCIATE ☐ TERM ASSOCIATE Effective Date: ________________

Associate Name: ____

Address: ____________________________________ City: ____________________ State: _____ Zip Code: ___________

Address: ____________________________________ City: ____________________ State: _____ Zip Code: ___________

Address: ____________________________________ City: ____________________ State: _____ Zip Code: ___________

***** COMPLETE BELOW SECTION FOR ADD'S ONLY *****

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Specialty: ____________________ ***Note: If left blank, associate will be added as a General Dentist***

If Specialist, Board Status: ☐ Certified ☐ Eligible – Indicate highest level of education ___________________________

☐ ADD ASSOCIATE ☐ TERM ASSOCIATE Effective Date: ________________

Associate Name: ____

Address: ____________________________________ City: ____________________ State: _____ Zip Code: ___________

Address: ____________________________________ City: ____________________ State: _____ Zip Code: ___________

Address: ____________________________________ City: ____________________ State: _____ Zip Code: ___________

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Title: ☐ DDS ☐ DMD Dental License #: _______________ Individual NPI #: _______________ Gender: ☐ M ☐ F

Specialty: ____________________ ***Note: If left blank, associate will be added as a General Dentist***

If Specialist, Board Status: ☐ Certified ☐ Eligible – Indicate highest level of education ___________________________

____
PRINTED NAME

____________________________________ ________________
SIGNATURE ***DATE***

To complete request, please fax this document to ATTN: Provider Relations at 402-467-7339 or email it to providerrelations@ameritas.com

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