

Instructions

Fill in all fields prior to submitting your application. Each Non-Participating Provider in a group practice must complete a separate profile. Please enclose a copy of the following with this completed profile:

1. Current state(s) license(s)
2. Specialty certification (if applicable)
3. Completed [IRS Form W-9](#)

Section 1 – Provider Information

Name (Last, First, Middle Initial)		Suffix (e.g., Jr., III)	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Social Security Number		Date of Birth (MM/DD/YYYY)	
NM State License Number		Specialty	
Individual National Provider Identification (NPI) Number Type 1			
Name of Dental College or University Attended		Graduation Date (MM/DD/YYYY)	

Section 2 – Primary Practice Location

Practice Name		
Group National Provider Identification (NPI) Number Type 2	Tax Identification Number (TIN)	
Practice Address (including City, State, and ZIP Code)		
Telephone	Fax	Office Email Address

Section 3 – Standard Authorization, Attestation, and Release

I certify that the information contained herein, including all supporting materials, is true and complete to the best of my knowledge and belief. I further agree to notify Delta Dental of New Mexico, in writing, of any change in the information I have provided in this document within 30 days of its occurrence.

I authorize the New Mexico Board of Dental Health Care (or other dental licensing agencies in any state in which I have been licensed to practice dentistry), and any health care facility, health maintenance organization, or professional organization with whom I have had employment, practice, association, or privileges, to release information to Delta Dental of New Mexico.

Provider’s Signature: _____ **Date:** _____

Please email a scanned copy of completed profile to nmproviderrequests@deltadentalnm.com.

Delta Dental of New Mexico
 Telephone: (800) 999-0963
 Fax: (888) 404-8725