



## FACILITY UPDATE FORM

Please complete entire form and fax to 501-992-1867

### CHANGE OF ADDRESS

Facility/ Business Name \_\_\_\_\_

Tax Identification Number \_\_\_\_\_

Change Applicable to:

Physical Address Only     Billing Address Only     Billing and Physical Address (same)

New Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

New Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Effective Date of Change: \_\_\_\_/\_\_\_\_/\_\_\_\_

Form Completed by: \_\_\_\_\_

**Your records will be updated accordingly upon receipt of this form along with a completed W-9 form. It is important to submit the requested information to us as quickly as possible to avoid any delays in claims processing.**

Delta Dental of Arkansas  
PO Box 15965  
North Little Rock, AR 72231

Telephone: 501-335-3400  
Fax: 501-992-1867