GEHA Connection Dental Network

Universal
Directory Update Form

Provider's Name:	Provider's NPI Number:
Gender:	Office NPI Number:
Specialty:	If Specialty is different than listed complete:
*Education Facility Name:	*Graduation Month/Year:
American Board Certifications:	
Hospital Privileges, if so Hospital Name(s):	
Office Name:	
Office Street:	
Office City:	Office State: / Office Zip:
Office Tax ID:	License Number:

Monday Hours:		**Tuesday Hours:**		**Wednesday Hours:**		**Thursday Hours:**	
Friday Hours:		**Saturday Hours:**		**Sunday Hours:**		Languages at Location:	

Office Email:	
Office Phone:	Office Fax:

1. Do you accept new patients? Yes / No
2. Is it difficult to schedule new patients? Yes / No
3. Do you schedule same day appointments? Yes / No
4. Are there any changes that affect your availability to patients? Yes / No
5. Does this location offer teledentistry? Yes / No
6. If yes, what platform do you utilize for teledentistry? _____
7. What form of teledentistry do you perform?
   - ☐ Asynchronous – Store & forward indirect conference
   - ☐ Synchronous – Live audio/video conference

8. Do you provide dental services via Mobile Dentistry? Yes / No
9. What city and state does the Mobile Dentistry provide service in? _____
10. What services do you perform via Mobile Dentistry?
    - ☐ Diagnostic
    - ☐ Preventative
    - ☐ Restorative
    - ☐ Other
11. Where is the Mobile Dentistry service performed?
    - ☐ Off-site patient/customer location
    - ☐ Mobile dentistry vehicle

By signing this form, I certify that the information provided is correct and that if any foreign languages are listed above, they are fluently spoken by a staff member of this office.

Name (printed): _____

Signature: _____ Date: _____

Fax: 816.257.3238 or Email: CDNstateverification@geha.com