GEHA Connection Dental Network.

Authorization for Release of Records to Practice Management Consultant - Group Contracted Please complete the form below and return to **CDNproviderinfo@geha.com**

CONSULTANT INFORMATION

Consultant Name: _____
Consultant Business Name: _____
Consultant Email: _____ Consultant Phone: _____
Consultant Street Address: _____
City: _____ State: _____ Zip: _____

GROUP DENTAL PRACTICE INFORMATION

Group Dental Practice Owner: _____
Name of Group: _____
Email Address: _____Office Phone:_____
Group IPA:_____
Tax ID: _____NPI2:_____
Practice Location: _____
City: _____State: _____ Zip:_____

PROVIDER ATTESTATION

I, _____as the Group Dental Practice Owner/Legally Authorized Representative of _____ (Group Dental Practice Name), hereby designate _____(Practice Management Consultant) to act as an authorized agent and take actions identified as follows:

1. Fee Schedule Review/Negotiation requests
2. Initial Credentialing and Re-Credentialing documentation
3. Inquiries relevant to existing contracts (network effective date, assigned fee schedule)
4. Additions, changes or updates to provider's practicing locations

I further authorize Connection Dental Network to send all of the records; related to such requests directly to the Practice Management Consultant at the email/fax/address set forth above. This authorization expires one year from the date of signature.

This authorization does *NOT* authorize the Practice Management Consultant to terminate the Group Participating Provider Agreement *NOR* address payor service Issues such as: incorrect EOBs, Par/Non Par Issues with outside payors, or modify outside payor incorrect directory information. (*An outside payor is any insurance carrier other than GEHA*)

Printed Name of Group Dental Practice Owner:_____
Signature of Dental Practice Owner:_____
Date Signed:_____

OR

Printed Name of Legally Authorized Representative: _____
Signature of Legally Authorized Representative:_____
Date Signed: _____