Authorization for Release of Records to Practice Management Consultant - Individually 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: _____

DENTAL PRACTICE INFORMATION

Practice Owner: _____
Name of Practice: _____
Email Address: _____Office Phone:_____
Tax ID: _____NPI 2:_____
Practice Location: _____
City: _____State: _____ Zip:_____
Note: If you have more than one Tax ID associated with more than one physical practicing location, please move to the next page and complete Exhibits A and B.

PROVIDER ATTESTATION

I, _____as the Practice Owner/Legally Authorized Representative of _____ (Practice Name), hereby designate _____(Practice Management Consultant) to act as an authorized agent (solely in connection with the Tax IDs and locations listed on Exhibits A and B) 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 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 Dental Practice Owner: _____
Signature of Dental Practice Owner: _____
Date Signed:_____

OR

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

GEHA Connection Dental Network.

Exhibit A

(Please complete or provide attachment with required information.)

Practice #1

Tax ID: _____
Email Address: _____
NPI 2 (if applicable): _____
Phone: _____
Practice Location Street Address: _____
City: _____ State: _____ Zip: _____

Practice #2

Tax ID: _____
Email Address: _____
NPI 2 (if applicable): _____
Phone: _____
Practice Location Street Address: _____
City: _____ State: _____ Zip: _____

Practice #3

Tax ID: _____
Email Address: _____
NPI 2 (if applicable): _____
Phone: _____
Practice Location Street Address: _____
City: _____ State: _____ Zip: _____

Exhibit B

(Please complete. If more than 8 providers, provide attachment with required information.)

	Provider Name:	**Provider NPI:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		