



# Diversified Dental Services, Inc.

## INFORMATION CHANGE REQUEST

Please check mark and update the change(s) you are requesting below.

Practice Name \_\_\_\_\_  
(Practice Name as appears on outside signage)

Business Phone Number \_\_\_\_\_

Business Fax Number \_\_\_\_\_

Remit Address (Insurance Payment Address)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, 9-digit Zip Code

Website \_\_\_\_\_

Email Address \_\_\_\_\_

Office Contact \_\_\_\_\_

**Please have owning dentist sign and date below.**

Owning Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Owning Dentist Name: \_\_\_\_\_

Office Location: \_\_\_\_\_

Return your completed form:

**FAX TO:**  
877-243-3816