

Please review the checklist below to ensure that we have all of the information and required documents we need to process your record update(s) efficiently.

All sections of the form must be completed -

- Record Update Needed** – Check all updates you are requesting
- Current Principal Record** – Provide information as currently on file at Principal
- Updated/New Information** – Provide new information to be updated in Principal records
- Contact & Dentist Info** – Must be completed in order to have updates processed

Be sure to include the following when submitting for -

- Dentist Name Update** – Dental license with updated name
- Dentist Licensure Type** – Dental license, Specialty Diploma & Certificate (if applicable)
- Dentist Languages Spoken** – List only those languages the individual dentist speaks
- Ownership Change** – Principal Agreement (signed by new owner), Copy of Bill of Sale, and updated W9
- DBA/Practice Name** – W9 and effective date of update
- Location Address** – W9 and effective date of update
- Location Phone number** – Effective date of update
- Location Email address** – Effective date of update
- Payee/Billing Name** – W9 and effective date of update
- Payee/Billing Address** – W9 and effective date of update
- Tax Identification Number (TIN)** – W9 and effective date of update
- Office Hours** – Complete all seven days
- Location Distinction** – Select one based on definition
 - Primary:** Dentist has a set/regular schedule available for patient care. (Name/location will appear in directory).
 - Secondary:** Dentist does NOT have a set/regular schedule but may infrequently provide care at location. (Claims will be processed as in-network).
- Terminate Location** – Attach letter with reason for termination, list of all dentists, and owner signature
- Terminate Dentist** – Attach letter with reason for termination and dentist signature

Return Completed Form AND Required Document(s) to:

Fax: 866-592-5970 or Email: DLGRPPFGPROVIDER@exchange.principal.com

**NOTE: This form cannot be used for New Add/Hire or Additional Location requests.
Please contact your Principal representative for assistance.**



Return Completed Form AND Required

Document(s) to:

Fax: 866-592-5970 or Email:

DLGRPPFGPROVIDER@exchange.principal.com

Principal Life
Insurance Company

Record
Update Form

Record Update Needed (check all that apply):

- Dentist Name
- Dentist Field of Practice
- Dentist Languages Spoken
- Ownership Change
- DBA/Practice Name
- Location Address
- Location Phone Number
- Location Email Address
- TIN
- Payee/Billing Name
- Payee/Billing Address
- Office Hours
- Location Distinction Update (Primary vs Secondary)
- Termination Location
- Terminate Dentist

Current Principal Record – Principal Plan Dental Participating Dentist? YES NO

First: _____ Middle: _____ Last: _____ Suffix: _____

Gender: Male Female Date of Birth: _____ Individual NPI: _____

Field of Dentistry: General Endodontics Orthodontics Oral Surgery Pedodontics Periodontics Prosthodontics

Languages Spoken by Dentist (other than English): _____

DBA/Practice Name: _____ Location currently listed as: Primary Secondary

Street: _____ Suite: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Email address for directory: _____

Group/Type II NPI: _____ Claims submitted: Electronically Paper

SSN or TIN for IRS Reporting: _____ Type: SSN TIN

Payee/Billing Name: _____

Payee/Billing Address (If different from above): _____

Office Hours (ie, 8:00-5:00): M _____ T _____ W _____ Th _____
F _____ Sa _____ Su _____

Updated Information – Effective date of Update: _____

First: _____ Middle: _____ Last: _____ Suffix: _____

Field of Dentistry: General Endodontics Orthodontics Oral Surgery Pedodontics Periodontics Prosthodontics

Languages Spoken by Dentist (other than English): _____

DBA/Practice Name: _____ Location currently listed as: Primary Secondary

Street: _____ Suite: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Email address for directory: _____

SSN or TIN for IRS Reporting: _____ Type: SSN TIN

Payee/Billing Name: _____

Payee/Billing Address (If different from above): _____

Office Hours (ie, 8:00-5:00): M _____ T _____ W _____ Th _____
F _____ Sa _____ Su _____

Contact Name: _____ Phone: _____ Email: _____

Dentist Signature: _____ Date: _____