

GROUP ACCOUNT CHANGE FORM

**Request for Addition and/or Deletion of a Provider(s)  
Identification Number to an Existing Group Account**

Name of Account \_\_\_\_\_ Account Number \_\_\_\_\_

Practice Address \_\_\_\_\_ Mailing Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

IRS # \_\_\_\_\_ Telephone # (\_\_\_\_\_) \_\_\_\_\_ Specialty \_\_\_\_\_  
 FAX # (\_\_\_\_\_) \_\_\_\_\_

DENTIST NAME (TYPED/PRINTED)	UCCI PROVIDER NUMBER	SOCIAL SECURITY NUMBER	INDIVIDUAL DENTIST SIGNATURE (REQUIRED FOR ADDITIONS)	ADDITION ①	DELETION ②
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

① *By my signature, I, as a member of this account, fully agree to abide by the Group Account requirements listed on the reserve side of this form.*

② *Deletions - Please provide the following information for providers being deleted from the Group Account.*

DENTIST NAME (TYPED/PRINTED)	UCCI PROVIDER NUMBER	NEW ADDRESS	NEW TELEPHONE NUMBER
_____	_____	_____	_____
_____	_____	_____	_____

## **United Concordia Companies Dental Group Account Agreement**

1. We hereby agree that, \_\_\_\_\_ (the "Account") will bill only for those services performed by the individual members of the Account.  
(Account Name)
2. We certify that the IRS Number given for the Account is the one assigned to the group. If this is not the case, we will identify the entity whose IRS Number is being used.
3. We certify that each member of the Account agrees to assign his/her fee to the Account.
4. We agree that every claim submitted for United Concordia Companies subscribers/beneficiaries will identify the the individual provider who performed the service.
5. We agree that the Account and each individual member will be jointly and severally liable for any overpayment that the Account may receive.
6. We agree to notify United Concordia Companies in writing of any subsequent changes in the membership of the Account prior to the effective date of each change.
7. We agree to timely completion and return of the United Concordia Companies *Dental Group Account Information Update* form. This form will be mailed to the Account each year for verification of current Account membership, location of practice, specialities of member providers, and other pertinent information. We understand that failure to respond may result in the termination of Dental Group Account.

- We have carefully reviewed the *Request for Dental Group Account* and *Dental Group Account Agreement*, and each member has
8. verified the accuracy and completeness of all information provided.

On behalf of the group, I verify that all members have reviewed this document and have authorized me to sign this Agreement on behalf of the Group.

**Please mail completed forms to:    United Concordia Companies, Inc.  
Provider Data Management  
P.O. Box 69415  
Harrisburg, PA 17110**

**Or**

**Fax to Provider Data Management at (717) 260-6834**