HNA
Health Networks of America

PROVIDER CHANGE REQUEST FORM

-A confirmation will be faxed upon receipt and completion of your request
-Print clearly in ink
-Allow up to 7 days for updates upon HNA receiving request form
-Change Request Form is valid only if agreement on page 2 is signed and dated.
*** NO ADDITIONAL DOCUMENT IS REQUIRED BESIDES OF THIS FORM

Current Practice Information

☐ Dental Provider ☐ Vision Provider Todays Date:_____

Provider Name:	Provider Phone #: Fax: Corporate Phone # (If Applicable):
Address, City, State, Zip code:	***Type of change:** ☐ Address Change ☐ Change of Specialty ☐ Location Change ☐ Change of Phone Number (Phone or Fax) ☐ Change of Doctor ☐ OTHER: _____
How Many Locations: 1 2-4 5+	How Many Doctors in Practice: 1 2-4 5+
Are all doctors in practice contracted to see policyholders: YES NO OTHER:_____	This change affects: ☐ Group Practice ☐ Individual Provider

New Provider Change Information

FILL OUT APPROPRIATE BOXES: (Write N/A if does not apply, or same as above)

Are you adding a location? YES NO Are you canceling a location? YES NO OLD Location:_____ _____ NEW Location:_____ _____	Doctors Name to add: *FILL OUT 'NEW DENTIST FORM' ON PAGE 2
Doctors to take off contract, and why?: 1)_____ 2)_____ REASON:	Change: FAX PHONE OLD Phone #:_____ NEW Phone#:_____
Old Specialty: ADD A SPECIALTY:	OTHER:

FOR OFFICE USE ONLY:

Date received: _____

Change effective: _____

Confirmation Sent: _____

- To network
- To providers list

HNA Signature:_____

Provider or Authorized Printed Name: _____

Provider or Authorized Signature: _____ DATE:_____

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NEW DENTIST FORM

Providers Name: _____
Contact Person: _____ Phone #: _____

New dentist(s) to add:	Specialty:	Address, City, State, ZIP:	S.S. or TIN No.
1)			
2)			
3)			

HNA Execution and Proxy Agreement

In order to complete credentialing by proxy, Health Networks of America requires only one set of credentialing documents of a managing doctor or owner doctor for **(_____)**.
Providers Office

I hereby affirm and represent that all statements, answers, and information contained in this application are true and to the best of my knowledge. It is also agreed upon, that this document is equivalent to the original execution form that has already been signed and dated by the provider or authorized executor, as well as the original Proxy form, which may or may not have been signed prior to this agreement, therefore any new providers and dentist(s) will comply to the original participation agreement/execution and proxy with Health Networks of America. To receive a copy of the original execution, you may contact HNA.

IN WITNESS WHEREOF, the parties have duly executed this Agreement as of the date set forth below.
Fax or photocopies of this document will be as binding as the originals.

CHECK ONE: __ Individual __ Authorized executor on behalf of group practice
Or practice management group

Provider or Authorized Printed Name _____

Provider or Authorized Signature _____ Date: _____

Tax Identification Number _____

HNA Administrator Printed Name _____

HNA Administrator Signature _____ Date: _____