Provider Update Form

(Save form to your desktop before filling out)

- All boxes with red lettering in must be completed if applicable. If a box does not apply, fill in with N/A
- Requests should be submitted at least 30 days prior to the effective date of change to allow time for processing. **To verify status, please call Provider Services at (866)438-5472, option 8.**
- Forms submitted without an effective date will be given a default date. *If **In Network** (PDP) **request** received prior to the 15th of the month an effective date of the 15th of the current month will be given. If the **In Network** (PDP) **request** form is received after the 15th of the month, an effective date of the 1st of the following month will be given.*
- **Send completed form(s):**
  - **E-mail:** ProviderUpdateForm@metlifeservice.com
  - **Fax:** 859-389-6505 Attn: Provider Update
  - **Mail:** MetLife Dental Claims Attn: Provider Unit, P.O. Box 981282 El Paso, TX 79998
- **If applicable, please notify clearinghouse company of any updates for address changes/TIN changes**

☐ **Check if Provider should be In-Network (PDP) with MetLife**
(If provider is not credentialed with MetLife or if box is left unchecked, Provider will be added as non-PDP)

Date:_____ **Contact Name:**_____ **PH:** _____ **E-mail (Recommended):** _____

Objective:

☐ **Adding location with New TIN - Include W-9 and provide effective date:** _____
☐ **Adding location with current TIN - Provide effective date:** _____
☐ **TIN Change - Provide W-9 and current list of Providers:** _____
Provide effective date of TIN Change: _____

☐ **Legal name Change – Provide W-9 showing the new legal name and a current list of providers** _____
☐ **Office moved - Provide list of current Providers and effective dates:** _____ **Phone #:** _____
☐ **Other….** _____

Provider Status Change: ☐ **Retired** ☐ **Deceased** ☐ **Left office** ☐ **Left Group**
Check appropriate box and provide effective date: _____

Dentist Information:

Dentist's Name (Print):	
License Number:	
State of Licensure:	
Dentist Individual NPI:	

Current Office Information:

TIN/Tax ID:	
Legal Name for TIN/Tax ID:	
Street Address:	
City/State/Zip:	
Phone Number:	
Office NPI:	
Billing Address (If different)	

Updated Information: (If more than one provider/office attach roster or duplicate page)

Legal Name for TIN/Tax ID:	
Practice Name/DBA:	
Street Address:	
City/State/Zip:	
Phone Number:	
Fax Number:	
E-Mail Address:	
TIN/Tax ID:	
Office NPI if applicable:	
Billing address (If different)	

- For EFT enrollment or to request a PDP Application, please visit https://dentalprovider.metlife.com