



ADDRESS CHANGE FORM

- Dentist Name: _____
- Dentist License #: CO _____
- Phone #: _____

PREVIOUS	CURRENT
ADDRESS:	ADDRESS:
PHONE #:	PHONE #:
FAX #	FAX #
TAX ID #:	TAX ID #:
IRS REGISTERED (BUSINESS ENTITY) NAME:	IRS REGISTERED (BUSINESS ENTITY) NAME:
EFFECTIVE LAST DAY:	EFFECTIVE START DATE:

SUBMITTED BY _____

DATE _____

Please return this completed form by mail or fax
Attention: PROVIDER RECORDS
PO. BOX 5468, DENVER CO 80217-5468
Fax: 303-741-2230
Thank you for your assistance