



Change Form – Billing Reports Online User

DELTA DENTAL OF NORTH CAROLINA

Please enter your information below and e-mail to billing@deltadentalnc.org or mail to Delta Dental of North Carolina, Attn: Billing Department, P.O. Box 9304, Minneapolis, Minnesota, 55440-9304.

- You will be notified by e-mail when your change information has been updated.

COMPANY INFORMATION

<p>#1) Main Company Contact Name (Please Print) _____</p> <p>Main Contact Phone Number _____-_____-_____</p> <p>Main Contact Address _____ _____ _____</p>	<p>#2) Account/Group Number _____</p> <p>#3) Date of request: _____</p> <p>_____ Authorized Signature</p> <p>Note: Person in your organization with proper authority to request billing information must sign this change request.</p>
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USER INFORMATION (check boxes and enter change information below as needed)

<p>Change Username <input type="checkbox"/> Current user's name and Job Title (person using the secured portion of the site): _____ _____</p> <p>Change user phone number <input type="checkbox"/> Current user phone number: _____-_____-_____</p> <p>Change user e-mail <input type="checkbox"/> Current user e-mail _____</p> <p>Change username <input type="checkbox"/> Current username _____</p>	<p>New user's name and Job Title (person using the secured portion of the site): _____ _____</p> <p>New user phone number: _____-_____-_____</p> <p>New user e-mail _____</p> <p>New username _____</p>
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<p>Change subgroup numbers <input type="checkbox"/> New Subgroup Numbers (If you have questions on completing this section, please call the Billing Department at 1-800-906-4702.) _____ _____ _____</p>	<p>New Subgroup Numbers (If you have questions on completing this section, please call the Billing Department at 1-800-906-4702.) _____ _____ _____</p>
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To be completed by Delta Dental

<p>Authorized: Yes <input type="checkbox"/> No <input type="checkbox"/> Incomplete Form <input type="checkbox"/></p>	<p>Reviewed/Authorized By: _____</p>
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