Providers should complete this form to request a change to a Member’s Dental Health Plan to a plan with whom the Provider is contracted. Please note that plan changes will be effective 3 days after a completed request has been received.

***Members should not complete this form. If a member would like to change their Dentall Health Plan, they should call 503-416-8090.***

**\*Indicates Required Field**

|  |
| --- |
| Date Form in Submitted to Health Share\*:       |
| Name of Person Completing Form\*:       |
| OHP Assister ID:       | [ ] N/A(not an OHP assister)  |
| Phone Number for Person Completing Form\*:       |
| Name of Organization Requesting Plan Change\*:       |

**Member Information**

|  |  |  |
| --- | --- | --- |
| OHP ID\*:       | **OR** | SSN\*:       |
| **A valid OHP ID or Social Security Number is required to correctly process this form.** |
| Last Name\*:       | First Name\*:       |
| Date of Birth\*:       |

**Primary Care Provider Information**

|  |
| --- |
| Primary Care Clinic:       |
| Primary Clinic Address:       |
| Primary Care Provider:       |

**Preferred Dental Health Plan Partner**

Please indicate the Member’s preferred Dental Health Plan (*select only one*):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Advantage [ ]  | CareOregon [ ]  |  Kaiser [ ]  |  ODS [ ]  |  Willamette [ ]  |

**Please send completed form to Health Share via Secure Fax: 503-459-5749 or Secure Email:** **rae.exceptions@healthshareoregon.org****.**