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**](mailto:rae.exceptions@healthshareoregon.org)**.**