Dental Health Plan Change Request Form

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 Submitted to Health Share*:

Requested Effective Date*:

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.

Last Revised: June 2019