



Change Form - Billing Reports Online Users

DELTA DENTAL OF MINNESOTA

Please enter your information below and e-mail to Billing@deltadentalmnadmin.org or mail to Delta Dental of Minnesota, Attn: Billing/AR Department, PO Box 9304, Minneapolis, Minnesota, 55440-9304.

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

COMPANY INFORMATION	
#1) Main Company Contact Name (Please Print) _____ Main Contact Phone Number _____ - _____ - _____ Main Contact Address _____ _____ _____	#2) Account/Group Number _____ #3) Date of request: _____ _____ Authorized Signature Note: Person in your organization with proper authority to request billing information must sign this change request.
USER INFORMATION (check boxes and enter change information below as needed)	
Change Username <input type="checkbox"/> Current user's name and Job Title (person using the secured portion of the site): _____ _____ Change user phone number <input type="checkbox"/> Current user phone number: _____ - _____ - _____ Change user e-mail <input type="checkbox"/> Current user e-mail _____ Change username <input type="checkbox"/> Current username _____	New user's name and Job Title (person using the secured portion of the site): _____ _____ New user phone number: _____ - _____ - _____ New user e-mail _____ New username _____
Change subgroup numbers <input type="checkbox"/> New Subgroup Numbers (If you have questions on completing this section, please call the Billing Department at 651-406-5902 or 1-800-906-4702) _____ _____ _____ _____ _____ _____ _____ _____ _____	New Subgroup Numbers (If you have questions on completing this section, please call the Billing Department at 651-406-5902 or 1-800-906-4702) _____ _____ _____ _____ _____ _____ _____ _____ _____
To be completed by Delta Dental	
Authorized: Yes <input type="checkbox"/> No <input type="checkbox"/> Incomplete Form <input type="checkbox"/>	Reviewed/Authorized By: _____