

HARBOR DENTAL PLAN

PROVIDER PROFILE AND ATTESTATION FORM

PLEASE TYPE OR PRINT IN BLACK INK

PROVIDER INFORMATION

Dentist Name: _____ Degree: _____ Specialty: _____
 DBA or Dental Group: _____
 Street Address: _____
 City: _____ County: _____ State: _____ Zip: _____
 Telephone Number: _____ Fax: _____
 Tax ID: _____ E-mail Address: _____
 Home Address: _____

How do you want to be listed? Dentist Name Group Name Both

License/Certificate	State	License/Certificate Number	Issue Date	Expiration Date
Dental License				
DEA Certificate				
CDS or State DPS				
Specialty Certificate/License				

LIABILITY INSURANCE INFORMATION

Name of Carrier: _____
 Street Address: _____
 City: _____ County: _____ State: _____ Zip: _____
 Telephone Number: _____ Fax: _____
 Policy Number: _____ Issue Date: _____ Expiration Date: _____
 Coverage Limits: _____ Per: Claim -or- Occurrence

ATTESTATION

I attest that the information provided on this form is correct and accurate. I further attest that the licenses, certificates and professional liability insurance as indicated above are all current.

 X
 Signature _____ Date _____

Printed Name _____ Title _____