AMERICAN DENTAL PLAN OF WISCONSIN, INC.

1221 John Q Hammons Dr. adp@sva.com 608-831-1047
P.O. Box 44966 1-800-257-0396
Madison, WI 53744-4966 fax 608-826-2116

REQUEST FOR A PROVIDER CHANGE

Please complete the entire form

This change request is for the following members. **List names to be changed only**:

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

Only members specifically listed above will be affected by this change.

This request is to change the designated dental provider from:

Dr. __________________________________ to Dr. ____________________________________

Please indicate the reason for the change in providers:

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For administrative reasons, the changes will be effective
the first (1st) day of the month following the receipt of this reply.
Please call if you have any questions regarding this matter.

Please complete all information below:

Employer's name ____________________________ Subscriber # ____________________________

Subscriber name ____________________________ SS # __________________________________

Subscriber address ____

____

Subscriber phone numbers: Home ________________________ Work __________________________

Signature __________________________________ Date __________________________________

****Please note: A maximum of TWO provider changes are allowed per calendar year.**