

PROVIDER CHECK LIST

Provider Information:

1. Provider Name (first and last) : _____
2. Provider Dental License #: _____
3. Previous Billing Tax ID #: _____
4. New Billing Tax ID #: _____

Please complete:

- Completed W9 form

Submit via fax or email:

- ◆ Fax: 209-478-5614
- ◆ Email: providerservices@cypressadmin.com



