**Vendor Name<Vendor Name Here>Open Dental & Change Healthcare**

**Provider Initiation Lead Form**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Practice legal name |  | | | | | |
| Practice address |  | | | | | |
| Practice city |  | | ST | CA | Zip |  |
| Primary Contact Name |  | | | | | |
| Primary Contact Phone |  | Primary Contact Email | |  | | |
| Enrollment Contact Name |  | | | | | |
| Enrollment Contact Phone |  | Enrollment Contact Email | |  | | |

|  |  |  |
| --- | --- | --- |
| Number of Providers |  | *Tax Id:*  *NPI #:* |
| Number of locations |  | Provider name: |

|  |  |
| --- | --- |
| Open Dental Go Live Date |  |
| Open Dental customer ID |  |
| Open Dental contact |  |

|  |  |
| --- | --- |
| Notes / Additional Information: |  |

**Email completed form to Physician Info at Physicianinfo@changehealthcare.com**