WHICH DACnet FORM TO USE.
Denturist is joining office Do not use this form. Use the DACnet Subscription Agreement form to add denturists to this office.
Denturist is leaving office Use this form to remove the denturist from this office. Use the DACnet Subscription Agreement form to add the denturist to another location.
Practice is moving or closing Use this form to change practice address and contact information, if the entire practice is moving to a location where there has not been a denturist office. The DACnet office number moves with the practice.
Practice is sold Use this form to remove current denturists from this office. Use DACnet Subscription Agreement form to add incoming denturists to this office and outgoing denturists to another office. The DACnet office number stays with the physical location.

Update Denturist Office Information

Fax the completed form to 613-902-2840.

1. Indicate Current Office Information (Current office information must be completed)

DACnet Office Number: ___ ___ ___ ___ Office Name: _____

Office Contact Name: _____

Address 1: _____

Address 2: _____

City, Province, Postal Code: _____

Telephone: (____) _____ Fax: (____) _____

Office Email: _____ Practice Software: _____

2. Office is Moving, Closing or there is a Change to Office Information

Office is:

☐ **Closing** (Will no longer be a denturist office at the current location.)

☐ **Moving** to a different location and all denturists in office are moving to different location. Indicate new office information below including the effective date.

☐ **Updating office information**. Indicate only the information that is changing below and the effective date. Complete Section 3 below to remove a denturist from the current location.

Office Name: _____

Address 1: _____

Address 2: _____

City, Province, Postal Code: _____

Telephone: (____) _____ Fax: (____) _____

Office Email: _____ Practice Software: _____

Effective Date: DD _____ MM _____ YY _____

3. Complete to Remove a Denturist from this DACnet office (Denturists will not be able to send claims from this office.)

Denturist 1: Denturist Name: First _____ Last _____

Denturist UIN: ___ ___ ___ ___ ___ ___ ___ ___ ___ Effective Date: DD _____ MM _____ YY _____

Denturist 2: Denturist Name: First _____ Last _____

Denturist UIN: ___ ___ ___ ___ ___ ___ ___ ___ ___ Effective Date: DD _____ MM _____ YY _____

4. Sign the completed form and fax to DACnet at 514-252-0392. (This section must be completed.)

_____ _____ DD _____ MM _____ YY _____

Completed by Authorized signature (no stamps) Date

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dacenetedi@gmail.com www.dacnet.ca