Sale of Dental Practice Form

SELLER INFORMATION

Name: _____ **License Number:** _____

Phone Number: _____ **Office Email:** _____

Name of Practice: _____ **TIN:** _____

Address of Practice: _____ **Dentist Email:** _____

Reason for Sale:

- ☐ Retiring
- ☐ Maintaining participation at the location under current TIN
- ☐ Working as an associate under purchasers TIN
- ☐ Relocating to a new location
- ☐ Moving out of state
- ☐ Deceased
- ☐ Other: _____

Seller's Forwarding Address: _____

If left blank, future payments and 1099 will be sent to the current business/payment address on file.

I (seller) understand that all payments made by Delta Dental of Kansas (DDKS) for patient claims submitted by me, for services dated on or before _____ (date of sale), will be issued in my name and, as required by law, said payments will be reported by DDKS to the Internal Revenue Service as my earnings.

Seller's Signature: _____ **Date:** _____

PURCHASER INFORMATION

Name: _____ **License Number:** _____

Phone Number: _____ **Office Email:** _____

Name of Practice: _____ **TIN:** _____

Address of Practice: _____ **Dentist Email:** _____

I (purchaser) understand patient claims for services provided after _____ (date of sale), must be submitted under my name and will be payable to me, according to my Participating Dentist Agreement with Delta Dental of Kansas (DDKS), or if I do not have a Participating Dentist Agreement with DDKS, will be payable to the enrollee according to the terms of the enrollee's group dental care contract.

Purchaser's Signature: _____ **Date:** _____

Required documentation for each treating dentist at this location:

- ☐ Participating Dentist Agreement
- ☐ PPO Agreement (for those in PPO network)
- ☐ W-9
- ☐ Credentialing Form
- ☐ EFT Direct Deposit Form with Voided Check or Bank Letter *(if applicable)*
- ☐ Proof of Sale (signature page of Bill of Sale/Dental Practice Purchase Agreement)

If there is more than one seller/purchaser, the above information must be provided (with all accompanying dated signatures) for each seller/purchaser on attached duplicate of this form.

Return to Delta Dental of Kansas:
email: PR@deltadentalks.com | fax: 316.462.3317 | mail: P.O. Box 789769 Wichita, KS 67278-9769, Attn: Professional Relations

800.733.5823 | DeltaDentalKS.com

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