



**Oregon Dental Service  
Report of National Provider ID Assignment**

Dentist Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Tax ID number: \_\_\_\_\_

National Provider ID: \_\_\_\_\_ Date of Assignment: \_\_\_\_\_

Dentist License Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please send to:

Oregon Dental Service  
Dental Professional Relations  
601 SW 2<sup>nd</sup> Ave  
Portland, OR 97204