

## NOTICE OF SALE OF PRACTICE

This is to notify Delta Dental that, pursuant to an agreement

S E L L E R	Name _____ <small>(print or type)</small>	License number _____
	Name of practice _____	Social Security number _____
	Address of practice _____ <small>(street)</small>	TIN _____
	City, State, ZIP code _____	
	<b>Seller's signature:</b> _____ Date: _____	

**If there is more than one seller, the above information must be provided on all sellers with accompanying dated signatures for each seller (you may use the back of this form).**

have sold the above practice to:

P U R C H A S E R	Name _____ <small>(print or type)</small>	License number _____
	Social Security number _____	TIN _____
	<b>Purchaser's signature:</b> _____ Date: _____	
	<b>If there is more than one purchaser, the above information must be provided on all purchasers with accompanying dated signatures for each purchaser (you may use the back of this form).</b>	

**I (seller)** understand that, pursuant to the foregoing sale, and in accordance with my Participating Dentist Agreement with Delta Dental, all payments made by Delta Dental for Attending Dentist's Statements submitted by one, **for services dated on or before** \_\_\_\_\_ (date of sale) **will be issued in my name** and that, as required by law, said payments will be reported by Delta Dental to the Internal Revenue Service as my earnings. \_\_\_\_\_  
(initials)

**I (purchaser)** understand that Attending Dentist's Statements 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, or if I do not have a Participating Dentist Agreement with Delta Dental, will be payable to the enrollee according to the terms of the enrollee's group dental care contract. \_\_\_\_\_  
(initials)

## Assignment of Payments

**Purchaser:** \_\_\_\_\_  
(print or type name)

**Purchaser's signature:** \_\_\_\_\_ Date: \_\_\_\_\_

has purchased the accounts receivable from:

**Seller:** \_\_\_\_\_

**Seller's signature:** \_\_\_\_\_ Date: \_\_\_\_\_  
(print or type name)

Please return this form to your local Delta Dental:

**Delta Dental of California**  
ATTN: Dentist Network Administration and Contracting  
P.O. Box 997330 – MS D12  
Sacramento, CA 95899-7330  
Or via Fax: 916-852-8995

**Delta Dental of Insurance Company**  
ATTN: Dentist Network Administration and Contracting  
P.O. Box 1809  
Alpharetta, GA 30023  
Or via Fax: 770-641-5395

**Delta Dental of Pennsylvania**  
ATTN: Dentist Network Administration and Contracting  
One Delta Drive  
Mechanicsburg, PA 17055-6999  
Or via Fax: 717-774-1770