



## CDHA Application for Unique Identification Number (UIN) Dental Hygiene Direct Billing

CDHA Membership Number: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

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

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Personal email: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

I certify that I meet the requirements to practise as an independent dental hygienist as set by the provincial regulatory body.

I have attached a photocopy of my licence/registration from my Provincial Regulatory Body.

Signature: \_\_\_\_\_

**Dental hygienists may only submit claims under their own UIN. For services provided by an associate dental hygienist, claims must be submitted under the UIN of the associate.**

### Independent Practice Network (IPN)

A Unique Identification Number (UIN) is included in your membership with the Independent Practice Network (IPN). This membership must be renewed yearly. [Click here](#) to learn more or to join the Independent Practice Network.

### Complete **both** pages and return to:

Mail: CDHA, 1122 Wellington St W, Ottawa, ON K1Y 2Y7

Fax: 613-224-7283

Email: [info@cdha.ca](mailto:info@cdha.ca)

*Applications are processed once a week, on Tuesday mornings. Completed applications must be received by end of day Monday to be included in Tuesday's processing.*



## CDHA Application for Unique Identifier Number for Dental Hygiene Direct Billing – Business Address Confirmation

*(The information recorded below will be provided to insurance providers for verification purposes only.)*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Do you have a professional dental hygiene corporation?      Yes     No

If yes, name: \_\_\_\_\_

### Business Address #1

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

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

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### Business Address #2 (if applicable)

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

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

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### Business Address #3 (if applicable)

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

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

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

*For more business address, please attach another sheet.*

If you would like to be assigned an Office number and process claims electronically, simply complete the *Electronic Billing Enrollment* form available [here](#).