



A nonprofit independent licensee of the Blue Cross Blue Shield Association

Application for Dental Enrollment

This application is **only** used for participation with Excellus Health Plan.
W-9 form, copy of the Malpractice (Liability) insurance, a copy of your New York State license
 Enrollment will not be processed without this documentation.

All fields must be completed.

Requested Effective Date:			
Last Name:	First Name:	Middle Initial:	Title (DMD or DDS, etc):
Date of Birth:	Social Security #:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race/Ethnicity—<i>for reporting purposes only.</i>			
American Indian or Alaskan Native (Not Hispanic or Latino)	<input type="checkbox"/>	Other	<input type="checkbox"/>
Asian (Not Hispanic or Latino)	<input type="checkbox"/>	Prefer Not to Say	<input type="checkbox"/>
Black or African American (Not Hispanic or Latino)	<input type="checkbox"/>	Two or More Races (Not Hispanic or Latino)	<input type="checkbox"/>
Hispanic or Latino	<input type="checkbox"/>	White/Caucasian (Not Hispanic or Latino)	<input type="checkbox"/>
Native Hawaiian or other Pacific Island (Not Hispanic or Latino)	<input type="checkbox"/>		
CAQH ID #:			
Individual NPI #:			
Individual Tax ID #:			
Group Name (If Applicable):			
Group Tax ID #:		Group NPI(s) #:	
License # & State:		DEA # & State:	
Medicare #:		Medicaid #:	
Primary Specialty (select one):		Orthodontist	
<input type="checkbox"/>	General Dentist	<input type="checkbox"/>	Pediatric Dentist
<input type="checkbox"/>	Endodontist	<input type="checkbox"/>	Periodontist
<input type="checkbox"/>	Oral Maxillofacial Surgery	<input type="checkbox"/>	Prosthodontist
Taxonomy code (required):			
Secondary Specialty (select one):		Orthodontist	
<input type="checkbox"/>	General Dentist	<input type="checkbox"/>	Pediatric Dentist
<input type="checkbox"/>	Endodontist	<input type="checkbox"/>	Periodontist
<input type="checkbox"/>	Oral Maxillofacial Surgery	<input type="checkbox"/>	Prosthodontist
Taxonomy code (required):			

Please provide only **ONE** Correspondence, **ONE** Remittance, and **ONE** Medical Records address. Each address can be the same or different, but **must** be identified as a valid United States Postal Service mailing address. If **PO BOX** information is used, the corresponding City, State and Zip Code for the PO BOX must be provided and no street level information present.

Office addresses **must** be identified by street level information with the corresponding City, State and Zip Code. PO BOX information is **not** allowed.

Primary Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	
Is this office Handicap accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this address used for Telehealth services? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	
Is this office Handicap accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this address used for Telehealth services? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Remittance Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	

Correspondence Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	

Medical Records Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	

Provider Signature: _____

Office Contact Name <i>(please type or print)</i> :	Office Contact Phone:
Office Contact Email <i>(please type or print)</i> :	
By checking this box you are opting-in to receiving e-alerts & correspondence via email: <input type="checkbox"/> Provider email address will need to be provided.	Provider Email Address <i>(please type or print)</i> :

Please attach the W-9 form, copy of the Malpractice (Liability) insurance, a copy of your New York State license and Fax or mail to the fax number or mailing address provided below.

Email:	ExcellusDentalEnrollment@excellus.com
Fax number:	315-731-2530
Address:	Excellus BCBS, Attn: Provider Relations, 333 Butternut Dr., Syracuse, NY 13214