Excellus

A nonprofit independent licensee of the BlueCross BlueShield 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, DDS, etc.)*
Date of Birth:	Social Security #:	Gender: ☐ Male ☐ Female	

Race/Ethnicity—***for reporting purposes only.***			
American Indian or Alaskan Native (Not Hispanic or Latino)	☐	Other	☐
Asian (Not Hispanic or Latino)	☐	Prefer Not to Say	☐
Black or African American (Not Hispanic or Latino)	☐	Two or More Races (Not Hispanic or Latino)	☐
Hispanic or Latino	☐	White/Caucasian (Not Hispanic or Latino)	☐
Native Hawaiian or other Pacific Island (Not Hispanic or Latino)	☐		

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
☐	General Dentist	☐	Pediatric Dentist
☐	Endodontist	☐	Periodontist
☐	Oral Maxillofacial Surgery	☐	Prosthodontist
Taxonomy code (*required*):			

Secondary Specialty (*select one*):			
		☐	Orthodontist
☐	General Dentist	☐	Pediatric Dentist
☐	Endodontist	☐	Periodontist
☐	Oral Maxillofacial Surgery	☐	Prosthodontist
Taxonomy code (*required*):			

Revised: 11/12/2024

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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: ☐ Yes ☐ No		Is this address used for Telehealth services? ☐ Yes ☐ No	

Additional Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	
Is this office Handicap accessible: ☐ Yes ☐ No		Is this address used for Telehealth services? ☐ Yes ☐ 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 ***(please type or print)***:	Office Contact Phone:
Office Contact Email ***(please type or print)***:	
By checking this box you are opting-in to receiving e-alerts & correspondence via email: Provider email address will need to be provided. ☐	Provider Email Address ***(please type or print)***:

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

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