Excellus
A nonprofit independent licensee of the BlueCross BlueShield Association

Application for Dental Enrollment

To begin the enrollment process, please complete all information as it applies. Mail or fax, along with the required documents, to:
Address: Excellus BCBS, Attn: Provider Relations, 12 Rhoads Dr, Utica, NY 13502 Fax number: 315-731-2530

Effective Date:	Group Name:	
Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security #:	Gender: ☐ Male ☐ Female

DEA Certificate #:	Medicare #:	Medicaid #:
Tax ID*:	Group Tax ID*:	License/Registration#*:
Individual NPI #:	Group NPI #:	Licensed State:
Are you board certified? ☐ Yes ☐ No	If yes, board name:	

Primary Specialty (*select one*):		**Secondary Specialty (*select one*):**	
☐ General [19]	☐ Orthodontist [62]	☐ General [19]	☐ Orthodontist [62]
☐ Endodontist [60]	☐ Pediatric Dentist [63]	☐ Endodontist [60]	☐ Pediatric Dentist [63]
☐ Oral Maxillofacial Surgery [61]	☐ Periodontist [64]	☐ Oral Maxillofacial Surgery [61]	☐ Periodontist [64]
	☐ Prosthodontist [65]		☐ Prosthodontist [65]
Taxonomy code(s):		Taxonomy code(s):	

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

Primary Office Address:			STE:
City:	County:	State:	Zip Code:
Office Phone:	Office Fax:	Email:	
Is this office Handicap accessible: ☐ Yes ☐ No		Public Transportation: ☐ Yes ☐ No	

Additional Office Address:			STE:
City:		State:	Zip Code:
Office Phone:	Office Fax:	Handicap accessible: ☐ Yes ☐ No	Public Transportation: ☐ Yes ☐ No

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.

Correspondence Address:			STE:
City:		State:	Zip Code:
Office Phone:	Office Fax:	Email:	

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

Medical Record Address:			STE:
City:		State:	Zip Code:
Office Phone:	Office Fax:		

Office Contact Name:	Office Phone:
Dental Provider Signature:	Date:

*** Please attach the W-9 form, copy of the Malpractice (Liability) insurance, and a copy of your New York State license.**
Enrollment will not be processed without this documentation.

Revised: 11/12/13