

Dental Provider Application



PLEASE CHECK AS APPLICABLE:

- General Practice
- Orthodontics
- Prosthodontics
- Endodontics
- Pediatric Dentistry
- Oral & Maxillofacial Surgery
- Periodontics
- Denturist
- Hygienist

TELL US ABOUT YOUR PRACTICE:

Practice Locations

Do you practice at more than one location? No Yes

If No, please provide the information requested below pertaining to your SOLE office.

If Yes, please fill in the information below pertaining to your PRIMARY practice. For any additional practices under the same Tax Identification Number, complete and attach an additional sheet.

Primary Practice Location

When submitting claims for services provided at this sole or primary office, I plan to use the following:

Federal Tax Identification Number _____

This identification number is registered with the IRS under the following name:

or

My Social Security Number _____

OFFICE

Office Name (e.g. Family Dental Center, etc.)		
Office Street Address		Office Suite #
Office City	State	Zip Code
Office Telephone Number	Office Fax Number	Office Manager
Email address:		
Website:		

BILLING OFFICE (If different from above)

Billing contact (if different from Office Manager)		Name of Billing Entity (if applicable)	
Billing Address (if different from office address)			Billing Suite #
Billing City		State	Zip Code
Billing Office Telephone Number		Billing Office Fax Number	

OTHER INFORMATION ABOUT YOUR SOLE OR PRIMARY OFFICE

Does your office submit claims electronically? No Yes

Please indicate the name of your practice management computer software vender:

Are you accepting new patients? No Yes

Regular Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Handicap access Office Restroom

PROVIDERS WHOSE SERVICES ARE BILLED UNDER THE TIN OF THE SOLE OR PRIMARY OFFICE

If you are a solo practice, the following Document Check List applies to you.

If your practice includes employees or partners (referred to in this Application as Providers) whose services are billed to Regence using the Applicant's Sole or Primary Office TIN, the Document Check List applies to you and to each provider.

DOCUMENT CHECK LIST

The following is a check list of documents which must be legible and included with your application.

- A photocopy of your current state dental license (with license number, issue date and expiration date)
- A photocopy of your specialty certifications(s)/ or general anesthesia or conscious sedation permit
- A photocopy of your current malpractice insurance certificate (with policy number, levels of individual, aggregate coverage and dates of coverage)
- A photocopy of your current Drug Enforcement Administration (DEA) certificate(s), if applicable.
- A W-9 form reflecting tax identification number utilized.
- Signed agreements and/or addenda, and supporting documents for all providers in the practice.

ATTESTATION

I hereby affirm and represent that I am authorized to sign this Dental Provider Application on behalf of the Applicant, and that all information disclosed and documentation provided to support this application, including the tax and residency disclosures below, are true and correct to the best of my knowledge.

1. The TIN or SSN disclosed above is correct (or I am waiting for a number to be issued to me), and
2. The Applicant is not subject to backup withholding because at least one of the following is true: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest of dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. The Applicant and all providers of the Applicant (if any) is/are U.S. citizens or authorized to work in the United States.

Note: The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

If any changes to the information provided to support this application occur which affect the Applicant's (or any of Applicant's providers) professional status, the Applicant agrees to notify Regence BlueShield within 10 days, in writing, of these changes.

Name (please print)	Signature	Date