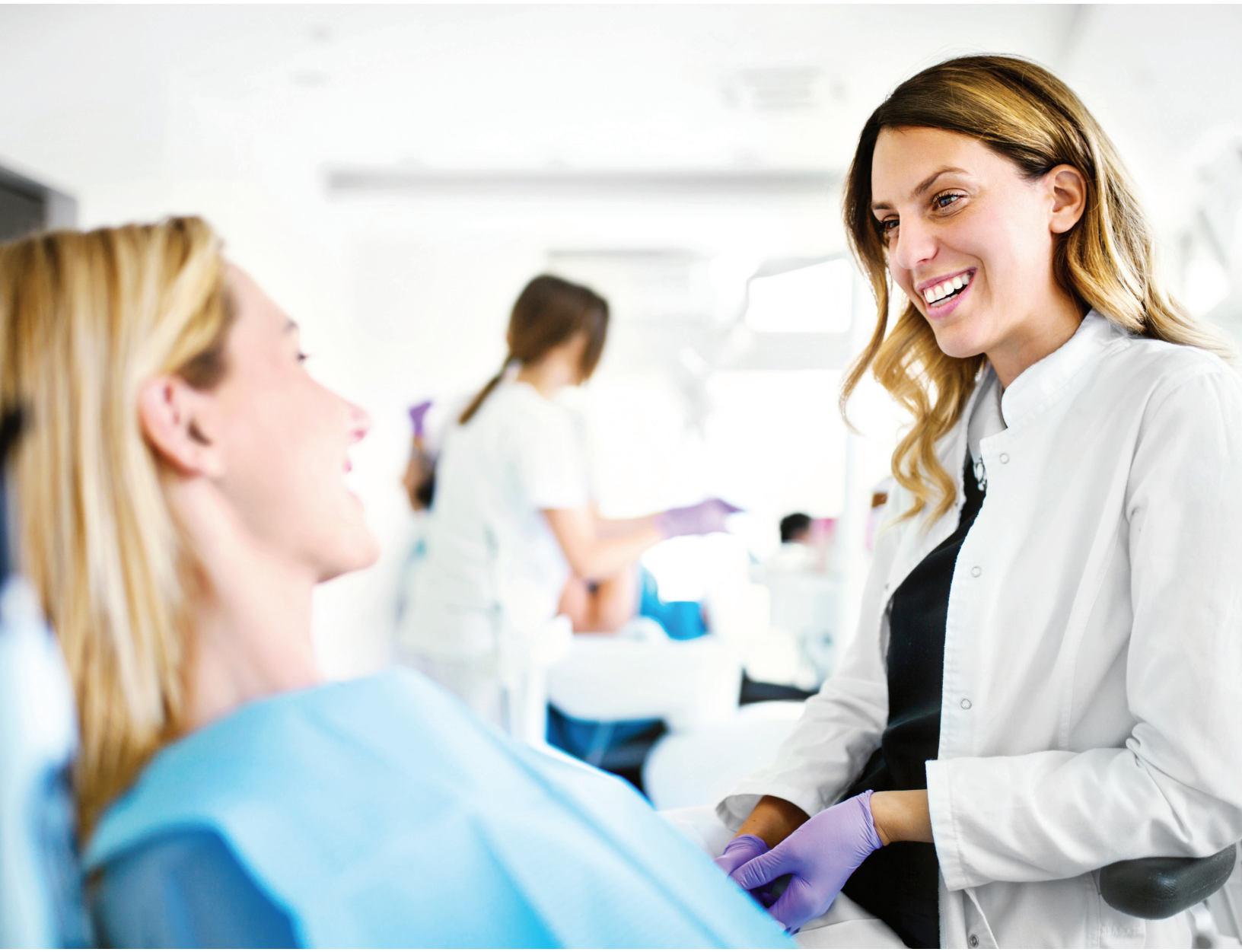
DENTAL PROVIDER APPLICATION–with CAQH



BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

APPLICATION FORM
DENTAL PROVIDER

BlueCross BlueShield Arizona

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Becoming a Blue Cross® Blue Shield® of Arizona (BCBSAZ) network provider starts with the application request and credentialing process. In order for your request to be considered, check that the following steps have been completed before sending your request:

Completion of this form requires all applicants to utilize the Council for Affordable Healthcare (CAQH). Requests that do not include a CAQH number cannot be completed and will be returned. If you do not currently have a CAQH number, please complete the **Dental Provider Application (Without CAQH)** form instead.

CONTACT PERSON *(Required)*	Name of contact person for questions related to this application and/or credentialing		
	Best way to contact you:	☐ Phone	☐ Email

We will notify the above contact person of any incomplete or missing information. If the required information is not received within 30 days, your request will be withdrawn and you will need to re-submit it for consideration.

INFORMATION YOU WILL NEED TO COMPLETE THIS REQUEST FORM

NPI (National Provider Identifier) Number – you should have one for your own individual use and your group should have one for the organization. For more information, see the federal National Plan & Provider Enumeration System (NPPES) website (nppes.cms.hhs.gov).

Arizona State License Number – including the date you were first licensed to practice in Arizona. Visit the Arizona Department of Health Services website (azdhs.gov/licensing) for more information.

DEA (Drug Enforcement Administration) Registration Number – if you are not registered, visit the federal DEA registration website (deadiversion.usdoj.gov).

PROVIDER INFORMATION				
Contract Type: ☐ **Dental** ☐ **FEP Dental (except Oral Surgeons)** ☐ **Medical (Sleep Apnea, TMJ and Oral Surgery)**				
CAQH PROVIDER ID *(Required)*	CAQH Provider ID Number			
PROVIDER NAME and DEGREE *(Required)*	Last	First	MI	Degree (MD, DO, etc.)
	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy) / /	Social Security - -	
OTHER NAME(S) USED	Last	First	MI	
INDIVIDUAL NPI *(Required)*	Individual NPI	Effective date (mm/dd/yyyy) / /		
TAX ID and START DATE *(Required)*	Tax ID Number (Employer Identification Number)	Date when provider started billing with this tax ID # (mm/dd/yyyy) / /		
LICENSE *(Required)*	License Number	Date you were first licensed to practice in AZ (mm/dd/yyyy) / /		
DEA REGISTRATION *(Required)*	DEA Registration Number	Expiration Date (mm/dd/yyyy) / /		
SPECIALTY *(Required)* Please note, what you indicate as your practicing specialty(s) will be how you are listed in the BCBSAZ provider directories.	Primary Practicing Specialty			
	Other Practicing Specialty(s), as applicable			
INDIAN HEALTH SERVICE PROVIDER *(Required)*	Are you an Indian Health Service Provider with the Federal Health Program for American Indians and Alaska Natives? ☐ Yes ☐ No			
OTHER LANGUAGES SPOKEN BY PHYSICIAN (Not staff)	1.	2.	3.	
ARE YOU ACCEPTING NEW PATIENTS? *(Required)* This information will be noted in our provider directory ☐ Yes ☐ No				

HOSPITAL /FREE STANDING SURGERY FACILITIES PRIVILEGES *(Required)* If space for additional facilities is needed, please attach a separate sheet.

Facility Name:	☐ Active ☐ Courtesy ☐ Delivery ☐ Provisional
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ASC PRIVILEGES (Facility Names):

GROUP INFORMATION *(Required)*
Claim payments may be made to the group name / NPI number.

Group's Legal Name – as on file with the AZ Corporation Commission

Group's DBA (Doing Business As) Name – if different from above

Group/Organization NPI	Effective date (mm/dd/yyyy)
	/ /

OFFICE CONTACT PERSON *(Required)*

Name of contact person for the practice (practice administrator/office manager) for business correspondence

Email	Phone	Fax

BUSINESS WEBSITE *(Required)*

Website

BUSINESS EMAIL *(Required)*
for contracts and correspondence

Provider Business Email (contracts and correspondence must be sent to the provider, not to a billing company or a consultant)

PRIMARY ADDRESS *(Required)*
Primary address must be a physical location in Arizona, where services are performed.

Street Address	Suite

City	State	Zip

Phone (Patient Scheduling Number)	Fax

Office Hours	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Start Time							
End Time							

BILLING ADDRESS *(Required)*
Contracted provider payments will be sent to this address.

Same as primary address: ☐ Yes ☐ No

Street Address	Suite

City	State	Zip

Phone	Fax

MAILING ADDRESS
If no mailing address is specified, correspondence will be sent to the billing address.

Same as billing address: ☐ Yes ☐ No

Street Address	Suite

City	State	Zip

Phone	Fax

Note about addresses: BCBSAZ sends claims payments to the provider's billing address. Unless a separate mailing address has been specified, other correspondence (including contract updates) is also sent to the billing address. An exception is medical and/or dental records requests, which are sent to the primary location address if a separate medical and/or dental records address is not specified.

CREDENTIALING CORRESPONDENCE If no address is specified for credentialing correspondence, it will be sent to the mailing address. If no mailing address is specified, the correspondence will be sent to the billing address.	Same as mailing address: ☐ Yes ☐ No			Same as billing address: ☐ Yes ☐ No			
	Street Address					Suite	
	City			State		Zip	
	Credentialing Correspondence Email		Phone		Fax		
MEDICAL AND/OR DENTAL RECORDS (If different than primary address)	Same as primary address: ☐ Yes ☐ No						
	Street Address					Suite	
	City			State		Zip	
	Medical and/or Dental Records Email		Phone		Fax		
ADDITIONAL OFFICE(S) FOR THIS TAX ID # Add only locations where the provider is actively practicing on a regular basis (attach an extra sheet if necessary). Do not include locations where the provider works occasionally or covers for other providers.	Please note: Claim processing for professional providers is based on NPI and tax ID number(s), not office locations.						
	Street Address					Suite	
	City			State		Zip	
	Phone		Fax		Authorization/Referral Fax		
	Office Hours	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
	Start Time							
	End Time							
Additional Information / Comments							

Authorized Electronic Provider Signature: I am _____ (name and title), and I verify that the information provided on the first three pages of this form is current and accurate. I agree that by entering my name in the electronic signature field below, I am verifying the information as provided.

/s/_____ _____/_____/_____

Authorized Electronic Provider Signature Date

Sign, save, attach, and email form and all required documentation to ProviderApps@dominionnational.com or fax to BlueDental℠ Administrator at 1-888-345-2040 • Questions? 1-888-271-7806

SUBMIT

If you have any questions regarding the contracting process, please contact **BlueDental Provider Network Relations at 1-888-271-7806.**

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