

Dental Provider Information Request

Please copy sheet and fill out for each individual provider that will be working under tax entity name and number of application. Also include the additional documents for each provider listed below.

Owner of the practice: Yes No

Name: _____ Male Female

Degree: DDS DMD LD RDH

Specialty: GP ENDO PERIO PEDO PROSTH

ORTHO RDH/LAP ORAL SURG DENTURIST

License #: _____ DEA #: _____

Individual NPI #: _____ TAX ID #: _____

Birth Date: _____ Start Date: _____

Office Location: _____

City _____ State _____ Zip Code _____

Phone #: _____ Email: _____

Please include:

- Photocopy of DEA Certificate
- Photocopy of malpractice insurance certificate
- Photocopy of specialty certificate (if applicable)
- Photocopy of W9

Please fax completed forms and requested documents to 1 (800) 331-3505 or mail to:

Regence BlueCross BlueShield of Oregon
Dental Services
PO Box 1271 M/S E9H
Portland, OR 97207