Blue Cross
Blue Shield
Blue Care Network
of Michigan

NEW INDIVIDUAL DENTIST ENROLLMENT

FAX OR MAIL COVER SHEET FOR DOCUMENTS

IMPORTANT: Attach this page to the top of your documents to avoid processing delays.

Fax To: 866-738-0243 Provider Enrollment

From:

Date:

Mail to: Dental Provider Enrollment
Blue Cross Blue Shield of Michigan
P.O. Box 3966
Southfield, MI 48037

Form Number: 11086

Dentist Name:

Type 1 NPI:

Tax Identification Number:

State License Number:

*Reporting an NPI is a requirement for electronic claims. Claims received without an NPI will be rejected.

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NEW INDIVIDUAL DENTIST ENROLLMENT

BCBSM Use Only 11086	Dentist Full Name	Type 1 NPI (National Provider Identifier required)
Tax Identification Number	State License Number	

Fax the completed form and any attachments to 866-738-0243. You can also mail the completed form to: Provider Enrollment, Blue Cross Blue Shield of Michigan, P.O. Box 3966, Southfield, MI 48037. Questions? Call Provider Enrollment at 1-888-334-6761.

BCBSM Requested Effective Date: _____

*If you would like to bill with your Type 2 NPI representing your incorporated individual business, you must **also** complete a New Group Enrollment form to register this entity as a group.

DEMOGRAPHIC DATA

First Name	Middle Name	Last Name	Suffix
Degree	Date of Birth	Gender ☐ Male ☐ Female	Social Security Number
Specialty			

Tax Identification Number (EIN or SSN)	EIN Name as Indicated on IRS Tax Document

ADDRESS DATA

Primary Office Address **Note: This must be an address where dental services are rendered and may be published in BCBSM provider directories.**

Street Address			
City	State	Zip Code	County

Primary Telephone Number **Note:** This must be a phone number patients can call to make an appointment.

Primary Telephone Number	Fax Number

Payment/Remit Address (if different from your primary address)

Street Address		
City	State	Zip Code

Mailing Address (if different from your primary address)

Street Address		
City	State	Zip Code

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APPLICATION SIGNATURE AND CONTACT

I certify that the information contained in this application is true and complete. I will notify Blue Cross and Blue Shield of Michigan immediately in writing of changes affecting this data. If I am a practitioner in training. I will not report services that are related to my training program and rendered at the address from which I am training. Should I re-enter training, I will notify BCBSM.

Print or Type Name _____ Provider/Signature Title _____ Date _____

Please provide the name and contact information of a person who can answer questions about information in this application.

First Name	Last Name
Phone Number	Fax Number
Email	Preferred method of contact? ☐ Email ☐ U S Mail

CHECK LIST

☐ Please include 147C from the IRS identifying EIN and Associated EIN Name.

*If you do not have this form please contact the IRS at 800-829-1040.