Blue Cross of Idaho

# Dentist Profile

**(PLEASE PRINT OR TYPE)**

Dentist Name: _____ Credentials: _____
(Last) (First) (Initial)

Practice or Group Name: _____

Office Type (check one):
☐ Group Practice ☐ Individual Practice w/Associates ☐ Individual Practice w/o Associates ☐ Multiple Locations

Business Tax Identification Number **(TIN):** ___ ___ - ___ ___ ___ ___ ___ ___ ___
*(Please include a signed and dated W-9 form)*

Individual National Provider Identification Number **(NPI):** ___ ___ ___ ___ ___ ___ ___ ____ ___ ___

Group National Provider Identification Number (if applicable): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Social Security Number **(SSN):** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ☐ Female ☐ Male

| DEA# | DEA Exp. Date | State License# | License Exp. Date | Specialty | Malpractice Carrier/Amounts/Policy # |
|---|---|---|---|---|---|
| | | | | | |

**Billing Address:** _____ County: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

**Primary Service Address**: _____ County: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

**Service Address (2)**: _____ County: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

Payments and correspondence for **Service Address (2)** should be mailed to:
☐ Billing address ☐ Service Address (1) ☐ Service Address (2)

Date Joined Clinic (or began practice): ___ / ___ /_____

Office Contact Person: _____ Email Address: _____



Fax form to: (208) 286-3575 **or** Mail to: Blue Cross of Idaho, P.O. Box 7408, Boise, ID 83707