

Provider Network Enrollment Request



BCBSKS and/or TRICARE

Use this document to **request network enrollment forms** for a new provider or group contract. Providing us with some preliminary information allows our staff to initiate the activity and customize an enrollment packet specific to your provider or group. It also ensures proper tracking as well as timely set-up of your provider record. Any paperwork necessary will be sent to the office contact person you have indicated below for completion.

Please complete Section 2 and/or Section 3 below as appropriate for your request. If Section 3 applies to your request we will need that information, **plus Section 2 information** for each provider tied to the group.

Fax or e-mail the completed request to:

Provider Network Services

Fax: (785) 290-0734

E-mail: Prof.Relations@bcbsks.com

Telephone: 1-800-432-3587 or (785) 291-4135, opt. 3

Attn: CC443D2, P.O. Box 239, Topeka, KS 66601

Please contact a Provider Network Services representative at the telephone number noted above if you have questions or if we can be of further service to you. We appreciate the opportunity to serve you.

Section 1 – Office Contact Information

First Name

Phone Number

Fax Number

Last Name

E-mail Address

Section 2 – New Provider

Contract(s) requested: BCBSKS CAP TRICARE

CAP Dental FEP Dental KC Dental

Is the provider employed by a prison, military base, Federal Indian Services Clinic or Veterans

If yes, which applies? _____

Administrative hospital? Yes No

Provider's First Name

CAQH Provider ID Number (if applicable – used for TRICARE only)

Provider's Last Name

Social Security Number

Tax ID Number

Location Address

Provider's NPI Number

Billing NPI Number

City

Provider's Specialty/Degree

State ZIP Code +4

Location Phone Number

Location Fax Number

Section 3 – New Group Contract

Contract(s) requested: BCBSKS CAP TRICARE

CAP Dental FEP Dental KC Dental

Entity Legal (W-9) Name

Social Security Number

Tax ID Number

Directory Name

Organizational or Subpart NPI Number(s) applicable

Location Address

Specialty

City

Location Phone Number

Location Fax Number

State ZIP Code +4

For each provider tied to the group, complete Section 2. Attach additional pages as needed.