220 Burnham Street ● South Windsor CT 06074
Vox 888-255-7293 ● Fax 860-289-0055

# PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **DORAL DENTAL OF WISCONSIN**

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
*(Number that will be used to submit electronic claims)*

Software Vendor: _____

Doral Location number: _____

Rendering Name and Doral Provider Number:

_____ _____

_____ _____

_____ _____

_____ _____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____