Dentist's Enrollment Information

We are glad that you have decided to participate as a provider in one of our dental programs. Simply complete the following form. An application will be sent to you and an enrollment coordinator will be assigned to answer any questions and facilitate the process.

Please note we only enroll and contract with Massachusetts dentists. Contact your local Delta Dental if you are from a different state.

Practice Name: ______________________________

Tax ID: ______________________________

Practice Type: ☐ Solo ☐ Group

Select Network to Join:

☐ Delta Dental Premier ☐ DeltaCare

☐ Delta Dental PPO ☐ DeltaCare Specialty

☐ Delta Dental EPO ☐ DeltaCare Orthodontics

Practice Address: ______________________________

City: ____________________ Zip Code: __________

Phone: ____________________

Fax: ____________________

Email: ____________________

Dentist(s)	License Number	Specialty

How would you like to receive the application?

☐ Email: ____________________

☐ Fax: ____________________

Return to:
Delta Dental of Massachusetts
Attn: Provider Enrollment & Credentialing
PO Box 9695
Boston, MA 02129

OR

email: DeltadentalCredentialingUpdates@greatdentalplans.com
FAX: 617-886-1414