Application for Dental Enrollment

This application is **only** used for participation with the Univera Healthcare

W-9 form, copy of the Malpractice (Liability) insurance, a copy of your New York State license

Enrollment will not be processed without this documentation.

All fields must be completed.

Requested Effective Date:			
Last Name:	First Name:	Middle Initial:	Title (DMD or DDS, etc):
Date of Birth:	Social Security #:	Gender: ☐ Male ☐ Female	

Race/Ethnicity—***for reporting purposes only.***

American Indian or Alaskan Native (Not Hispanic or Latino)	☐	Other	☐
Asian (Not Hispanic or Latino)	☐	Prefer Not to Say	☐
Black or African American (Not Hispanic or Latino)	☐	Two or More Races (Not Hispanic or Latino)	☐
Hispanic or Latino	☐	White/Caucasian (Not Hispanic or Latino)	☐
Native Hawaiian or other Pacific Island (Not Hispanic or Latino)	☐		

Individual NPI #:	
Individual Tax ID #:	
Group Name (*If Applicable)*:	
Group Tax ID #:	Group NPI(s) #:
License # & State:	DEA # & State:
Medicare #:	Medicaid #*:*

Primary Specialty (*select one*):			Orthodontist
	General Dentist		Pediatric Dentist
	Endodontist		Periodontist
	Oral Maxillofacial Surgery		Prosthodontist
Taxonomy code (*required*):			
Secondary Specialty (*select one*):			Orthodontist
	General Dentist		Pediatric Dentist
	Endodontist		Periodontist
	Oral Maxillofacial Surgery		Prosthodontist
Taxonomy code (*required*):			

univera HEALTHCARE

Please provide only **ONE** Correspondence, **ONE** Remittance, and **ONE** Medical Records address. Each address can be the same or different, but ***must*** be identified as a valid United States Postal Service mailing address. If **PO BOX** information is used, the corresponding City, State and Zip Code for the PO BOX must be provided and no street level information present.

Office addresses ***must*** be identified by street level information with the corresponding City, State and Zip Code. PO BOX information is ***not*** allowed.

Primary Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	
Is this office Handicap accessible: ☐ Yes ☐ No		Is this address used for Telehealth services? ☐ Yes ☐ No	

Additional Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	
Is this office Handicap accessible: ☐ Yes ☐ No		Is this address used for Telehealth services? ☐ Yes ☐ No	

Remittance Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	

Medical Records Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	

Correspondence Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	

Provider Signature: _____

Office Contact Name ***(please type or print)*** :	Office Contact Phone:
Office Contact Email ***(please type or print) :***	
By checking this box you are opting-in to receiving e-alerts & correspondence via email: Provider email address will need to be provided. ☐	Provider Email Address ***(please type or print)*** :

Please attach the W-9 form, copy of the Malpractice (Liability) insurance, a copy of your New York State license and Fax or mail to the fax number or mailing address provided below.

Fax number:	716-857-4578
Email:	UniveraPR@Univerahealthcare.com

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