Application for Dental Enrollment

To begin the enrollment process, please complete all information as it applies.

*** Please attach the W-9 form, copy of the Malpractice (Liability) insurance, and a copy of your New York State license.**
Enrollment will not be processed without this documentation.

*Are you enrolling in the Health Plan due to **COVID-19** pandemic?* ☐ *Yes* ☐ *No*

Effective Date:	Group Name:	
Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security #:	Gender: ☐ Male ☐ Female

Individual NPI #:	Group NPI #:	License/Registration #:
Tax ID:	Group Tax ID:	Licensed State:
Medicare #:	DEA Certificate #:	

***Medicaid #: (*required*)** ***To be enrolled in Medicaid products, an *active* Medicaid ID is required.**

Primary Specialty (*select one*):		**Secondary Specialty (*select one*):**	
☐ General [19]	☐ Orthodontist [62]	☐ General [19]	☐ Orthodontist [62]
☐ Endodontist [60]	☐ Pediatric Dentist [63]	☐ Endodontist [60]	☐ Pediatric Dentist [63]
☐ Oral Maxillofacial Surgery [61]	☐ Periodontist [64]	☐ Oral Maxillofacial Surgery [61]	☐ Periodontist [64]
	☐ Prosthodontist [65]		☐ Prosthodontist [65]
Taxonomy code (*required*):		**Taxonomy code (*required*):**	

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

Primary Office Address:			STE:
City:	State:	Zip Code:	County:
Phone *(required)* :	Office Fax:		
Is this office Handicap accessible *(required)* : ☐ Yes ☐ No		Public Transportation: ☐ Yes ☐ No	

Primary Office Address:			STE:
City:	State:	Zip Code:	County:
Phone *(required)* :	Office Fax:		
Is this office Handicap accessible *(required)* : ☐ Yes ☐ No		Public Transportation: ☐ Yes ☐ No	

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.

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

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

Medical Record Address:			STE:
City:		State:	Zip Code:
Office Phone:	Office Fax:		

Office Contact Name/Phone ***(please type or print)*** :
Office Contact Email ***(please type or print) :***

Provider Signature:	Date:

Mail or fax, along with the required documents, to:
Address: Univera Healthcare, Attn: Providers Relations, 205 Park Club Lane, Buffalo, NY 14221 or fax to: 716-857-4578

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