



Application for Dental Enrollment

To begin the enrollment process, please complete all information as it applies. Mail or fax, along with the required documents, to:
 Address: Univera Healthcare, Attn: Provider Relations, 205 Park Club Lane, Buffalo NY 14221 Fax number: 716-857-4578

Effective Date:	Group Name:	
Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security #:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

DEA Certificate #:	Medicare #:	
Tax ID*:	Group Tax ID*:	License/Registration#*:
Individual NPI #:	Group NPI #:	Licensed State:
Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, board name:	

Primary Specialty (select one): <input type="checkbox"/> General [19] <input type="checkbox"/> Endodontist [60] <input type="checkbox"/> Oral Maxillofacial Surgery [61]	<input type="checkbox"/> Orthodontist [62] <input type="checkbox"/> Pediatric Dentist [63] <input type="checkbox"/> Periodontist [64] <input type="checkbox"/> Prosthodontist [65]	Secondary Specialty (select one): <input type="checkbox"/> General [19] <input type="checkbox"/> Endodontist [60] <input type="checkbox"/> Oral Maxillofacial Surgery [61]	<input type="checkbox"/> Orthodontist [62] <input type="checkbox"/> Pediatric Dentist [63] <input type="checkbox"/> Periodontist [64] <input type="checkbox"/> Prosthodontist [65]
Taxonomy code(s):		Taxonomy code(s):	

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:	County:	State:	Zip Code:
Office Phone:	Office Fax:	Email:	
Is this office Handicap accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No		Public Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional Office Address:			STE:
City:		State:	Zip Code:
Office Phone:	Office Fax:	Handicap accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Public Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> 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:	Email:	

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:	Office Phone:
Dental Provider Signature:	Date:

*** 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.**