



Application for Dental Enrollment

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

W-9 form, copy of the Malpractice (Liability) insurance, and a copy of your New York State license must also be submitted.

Enrollment will not be processed without this documentation.

Requested Effective Date:			
Last Name:	First Name:	Middle Initial:	Title (DMD or DDS, etc):
Date of Birth:	Social Security #:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Race/Ethnicity— <i>for reporting purposes only.</i>	
American Indian or Alaskan Native (Not Hispanic or Latino) <input type="checkbox"/>	Other <input type="checkbox"/>
Asian (Not Hispanic or Latino) <input type="checkbox"/>	Prefer Not to Say <input type="checkbox"/>
Black or African American (Not Hispanic or Latino) <input type="checkbox"/>	Two or More Races (Not Hispanic or Latino) <input type="checkbox"/>
Hispanic or Latino <input type="checkbox"/>	White/Caucasian (Not Hispanic or Latino) <input type="checkbox"/>
Native Hawaiian or other Pacific Island (Not Hispanic or Latino) <input type="checkbox"/>	

CAQH ID #:	
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):



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: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this address used for Telehealth services? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional Address:			STE:
City:	County:	State:	Zip Code:
Phone:		Fax:	
Is this office Handicap accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this address used for Telehealth services? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <i>(please type or print)</i> :	Office Contact Phone:
Office Contact Email <i>(please type or print)</i> :	
By checking this box you are opting-in to receiving e-alerts & correspondence via email: Provider email address will need to be provided. <input type="checkbox"/>	Provider Email Address <i>(please type or print)</i> :

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:	providerenrollmentunivera@univerahealthcare.com