



Physician Extender Agreement Registration Form

Complete this form and fax it and the attachments requested to (716) 857-4578, or mail all materials to
Provider Relations, 205 Park Club Lane, Buffalo, NY 14221-5239



Applicant Name: _____ Effective Date of Registration: _____

Date of Birth: _____ Sex: M F

Check one: NP PA CDE Nutritionist

Demographic Information

Office Address: _____ City: _____ ST: _____ Zip: _____

Office Phone: _____ Cell: _____ Fax: _____ Pager: _____

2nd Office Address: _____ City: _____ ST: _____ Zip: _____

Billing Address (if different than above) _____ City: _____ ST: _____ Zip: _____

NPI Billing No: _____ Billing Phone: _____

Education/Licenses

(Please attach a copy of your license as listed below.)

Graduate School: _____ Expiration Date: _____ Degree: _____
(M/D/Y)

License No: _____ Expiration Date: _____
M/D/Y

DEA No.: _____ Expiration Date: _____
M/D/Y

Medicaid No.: _____ Medicare No.: _____ NPI No.: _____

Liability Insurance

(Please attach copy of current certificate.)

Policyholder Malpractice Insurance (choose one): Self Collaborating Physician Other

(Please attach copy of current W9 form.)

Collaborating Physician Information and Agreement

Collaborating Physician Name: _____ Specialty: _____

Physician's NPI No. _____ Group NPI No.: _____
(If part of a group)

Medical Practice Group Name: _____ Billing Tax ID No.: _____

I, the undersigned, hereby verify and attest that I am the collaborating physician for the above-named applicant. As required by applicable laws, I have satisfied myself as to the ability and competency of this applicant and that the functions that the applicant will carry out are performed under my collaboration and oversight.

Collaborating Physician's Name (print name): _____

Collaborating Physician: Signature: _____

Date: _____