univera HEALTHCARE

Practitioner Demographic Changes

Complete and return with the W-9 and malpractice (liability) insurance by mail or fax to the address below.

Effective Date:	Name:		
Individual NPI #:	Social Security # ***(required):***		Date of Birth:
DEA Certificate #:	State:	Language(s) [other than English]:	
License #:	State:	Office Contact Name and Phone/Ext: ***(please type or print):***	
Medicaid # ***(required):*** **(To be enrolled in Medicaid products, an *active* Medicaid ID number is required)**		Office Contact Email: ***(please type or print):***	
Medicare #:	Experienced HIV/AIDS Provider: ☐ Yes ☐ No	Accepting New Patients: ☐ Yes ☐ No	
Type of Change:	☐ ADD	☐ UPDATE	☐ TERMINATE—allow 45 days prior to termination

Any nurse practitioner (NP), physician assistant (PA), registered nurse first assistant, or certified behavior analyst assistant (BCaBA) that has a collaborating relationship with the terminated licensed physician must complete an *Application for Non-Physician Health Care Practitioner* to be reassigned.

Change to:	☐ NAME (provider/group)	☐ ADDRESS	☐ TELEPHONE/FAX	☐ NPI	☐ TAXONOMY/SPECIALTY	☐ TAX ID (*W-9 form must be attached)

Tax Information: (Current)	Tax ID Number:	Tax ID Name:
Tax Information: (*New)	Tax ID Number:	Tax ID Name:
Group Information:	Group NPI:	Group Name:
	Group NPI:	Group Name:
Specialty Information:	Primary Specialty:	Taxonomy Code:
	Second Specialty:	Taxonomy Code:

Please note: Addresses ***must*** be identified by street level information with the corresponding City, State and ZIP code, and 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 there should be no street level information present.

Address A

☐ New Address	☐ Term Address	❍ Primary Office	❍ Additional Office	❍ Correspondence	❍ Remittance	❍ Medical Record

Address:	STE:	City:	State:	ZIP Code:
Phone ***(required):***	Fax:			

Handicap accessible ***(required)***: ☐ Yes ☐ No	Public Transportation: ☐ Yes ☐ No
List address in directory ***(required)***: ☐ Yes ☐ No	Provider is Hospitalist at this address: ☐ Yes ☐ No

Office Hours	Mon ____-____	Tue ____-____	Wed ____-____	Thu ____-____	Fri ____-____	Sat ____-____	Sun ____-____

Address B

☐ New Address	☐ Term Address	❍ Primary Office	❍ Additional Office	❍ Correspondence	❍ Remittance	❍ Medical Record

Address:	STE:	City:	State:	ZIP Code:
Phone ***(required):***	Fax:			

Handicap accessible ***(required)***: ☐ Yes ☐ No	Public Transportation: ☐ Yes ☐ No
List address in directory ***(required)***: ☐ Yes ☐ No	Provider is Hospitalist at this address: ☐ Yes ☐ No

Office Hours	Mon ____-____	Tue ____-____	Wed ____-____	Thu ____-____	Fri ____-____	Sat ____-____	Sun ____-____

Address C

☐ New Address	☐ Term Address	❍ Primary Office	❍ Additional Office	❍ Correspondence	❍ Remittance	❍ Medical Record

Address:	STE:	City:	State:	ZIP Code:
Phone ***(required):***	Fax:			

Handicap accessible ***(required)***: ☐ Yes ☐ No	Public Transportation: ☐ Yes ☐ No
List address in directory ***(required)***: ☐ Yes ☐ No	Provider is Hospitalist at this address: ☐ Yes ☐ No

Office Hours	Mon ____-____	Tue ____-____	Wed ____-____	Thu ____-____	Fri ____-____	Sat ____-____	Sun ____-____

Practitioner's signature:_____ *(Signature not required if form is submitted online through provider portal. No signature stamps will be accepted.)*	Date:

Submit this completed form online at: Provider.UniveraHealthcare.com, or mail or fax to the address below:

Address: Univera Healthcare, Attn: Provider Relations, 205 Park Club Lane, Buffalo, NY 14221	Fax Number: 1-716-857-4578