univera HEALTHCARE

Practitioner Demographic Changes

This demographic change form is only used for participation with the Univera Healthcare

Complete and return with the W-9 and malpractice (liability) insurance by email, mail or fax to the address on page 2.
All necessary fields must be completed.

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.

Requested Effective Date of Change:

Type of Change:	☐ Add	☐ Update	☐ Terminate - Allow 45 days prior to termination.

Change to:	☐ Address	☐ NPI	☐ Name (Provider/ Group)	☐ Tax ID (W9 must be attached)	☐ Taxonomy/ Specialty	☐ Telephone/ Fax	

Last Name:	First Name:	Middle Initial:	Title (MD, DO, PhD, etc.)

Individual NPI #:	Date of Birth:
License #/State:	DEA Certificate #/State:
Experienced HIV/AIDS Provider ☐ Yes ☐ No	Accepting New Patients: ☐ Yes ☐ No
Medicare ID #: To be enrolled in Medicare products, an active Medicare ID number is required	Medicaid ID #: To be enrolled in Medicaid products, an active Medicaid ID number is required

What language(s) are you fluent in when speaking about medical care? *Check all that apply.*

☐ Arabic	☐ ASL	☐ English	☐ French
☐ Mandarin	☐ Nepali	☐ Russian	☐ Somali
☐ Spanish	☐ Ukrainian	☐ Vietnamese	☐ Other:

What language services are available at your location? *Check all that apply.*

☐ Bi-Lingual Staff	☐ On Site Interpreter
☐ Remote Interpreter - Audio	☐ Remote Interpreter - Video

Race - *to be shared with members upon request*

☐ American Indian or Alaskan Native	☐ Other
☐ Asian	☐ Prefer Not to Say
☐ Black or African American	☐ White
☐ Native Hawaiian or other Pacific Island	

Ethnicity - *to be shared with members upon request*

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer Not to Say

Practice Information: (Current)	Tax ID Number:	Tax ID Name:
	Group NPI:	Group Name:

Specialty/Taxonomy Code	Specialty:	Taxonomy Code: *(required)*
	Specialty:	Taxonomy Code: *(required)*

Proceed to Page 2 for address information.

Please provide the *required* addresses: Primary Office, Correspondence, Remittance, *and* Medical Records. 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.

AN ADDRESS TYPE MUST BE CHECKED FOR EACH ADDRESS SECTION USED.

Address A	☐ New Address	☐ Term Address	Is this address Handicap accessible? ☐ Yes ☐ No		
Address Type	☐ Primary	☐ Additional	☐ Remittance	☐ Correspondence	☐ Medical Records
Address: Ste:			City	State:	Zip Code:
Phone:	Fax:		Is this address used for "Telehealth services." ☐ Yes ☐ No		
Provider Hospitalist at this address? ☐ Yes ☐ No			List this address in the directory: ☐ Yes ☐ No Only check YES if patients are able to schedule an appointment at this location.		
Hours available to see patients*	Mon ___-___	Tues ___-___	Wed ___-___	Thu ___-___	Fri ___-___	Sat ___-___	Sun ___-___

Address B	☐ New Address	☐ Term Address	Is this address Handicap accessible? ☐ Yes ☐ No		
Address Type	☐ Primary	☐ Additional	☐ Remittance	☐ Correspondence	☐ Medical Records
Address: Ste:			City	State:	Zip Code:
Phone:	Fax:		Is this address used for "Telehealth services." ☐ Yes ☐ No		
Provider Hospitalist at this address? ☐ Yes ☐ No			List this address in the directory: ☐ Yes ☐ No Only check YES if patients are able to schedule an appointment at this location.		
Hours available to see patients*	Mon ___-___	Tues ___-___	Wed ___-___	Thu ___-___	Fri ___-___	Sat ___-___	Sun ___-___

Address C	☐ New Address	☐ Term Address	Is this address Handicap accessible? ☐ Yes ☐ No		
Address Type	☐ Primary	☐ Additional	☐ Remittance	☐ Correspondence	☐ Medical Records
Address: Ste:			City	State:	Zip Code:
Phone:	Fax:		Is this address used for "Telehealth services." ☐ Yes ☐ No		
Provider Hospitalist at this address? ☐ Yes ☐ No			List this address in the directory: ☐ Yes ☐ No Only check YES if patients are able to schedule an appointment at this location.		
Hours available to see patients*	Mon ___-___	Tues ___-___	Wed ___-___	Thu ___-___	Fri ___-___	Sat ___-___	Sun ___-___

Address D	☐ New Address	☐ Term Address	Is this address Handicap accessible? ☐ Yes ☐ No		
Address Type	☐ Primary	☐ Additional	☐ Remittance	☐ Correspondence	☐ Medical Records
Address: Ste:			City:	State:	Zip Code:
Phone:	Fax:		Is this address used for "Telehealth services." ☐ Yes ☐ No		
Provider Hospitalist at this address? ☐ Yes ☐ No			List this address in the directory: ☐ Yes ☐ No Only check YES if patients are able to schedule an appointment at this location.		
Hours available to see patients*	Mon ___-___	Tues ___-___	Wed ___-___	Thu ___-___	Fri ___-___	Sat ___-___	Sun ___-___

** If Primary Care Physician (PCP), office hours required*

Office/Contact name and phone number *(Please print or type):*
Office/Contact email address *(Please print or type):*

Practitioner's signature _____ *Date:* _____

(Signature not required if form is submitted online through provider portal)

Ways to submit completed form, W9 and Malpractice (liability) Insurance:	
Email: UniveraPR@UniveraHealthcare.com	Provider portal (E-Form): Provider.UniveraHealthcare.com
Fax: 716-857-4578	
Mail: Univera Healthcare, Attn: Provider Relations, 205 Park Club Lane, Buffalo, NY 14221	