

ENROLLMENT APPLICATION

REQUIRED DOCUMENTATION CHECKLIST

Please submit current copies of ALL of the documentation listed below. Any missing or inaccurate information will delay the enrollment process.

<input type="checkbox"/>	<p>Application for Practitioner Enrollment</p> <ul style="list-style-type: none"> • Complete all sections and especially the <i>required</i> fields, Social Security number and Taxonomy Code. • All addresses: <ul style="list-style-type: none"> • Primary Office • Remittance • Correspondence • Medical Record
<input type="checkbox"/>	<p>A Council for Affordable Quality Health Care (CAQH) number is required. You can self-register on the CAQH website (www.caqh.org). Please ensure that your CAQH information is completed and released to us with the most up-to-date information.</p>
<input type="checkbox"/>	<p>W-9 Request for Taxpayer Identification Number and Certification</p>
<input type="checkbox"/>	<p>Proof of Malpractice (liability) insurance - Minimum amount of \$1 million per occurrence and \$3 million aggregate. Ensure certificate has effective date, (current) expiration date, and coverage amounts.</p>
<input type="checkbox"/>	<p>(Current) Curriculum Vitae (CV)</p>
<input type="checkbox"/>	<p><u>For doulas only:</u></p> <ul style="list-style-type: none"> • Submit the Application for Practitioner Enrollment as instructed above • No CAQH number required • No proof of malpractice required • Submit W-9 Request for Taxpayer Identification Number and Certification with your Social Security number • Include a copy of NYS Medicaid provider enrollment approval letter and NYS Medicaid Doula Attestation form, signed by you, confirming that you have completed training for all core competencies

We will notify you when your application has been approved. Upon notification, you will be considered a participating provider in our network. Prior to receiving this notification, you are **not** considered in-network.

Credentialing applications are usually processed within 90 days of receipt. Please ensure that applications are completed in their entirety, signed, and all supporting documentation included.

Application for Practitioner Enrollment

To begin the enrollment process, please complete all information as it applies to your specialty. Information that does not apply to your specialty may be left blank.

Please attach the W-9 form and a copy of the malpractice (liability) insurance. Enrollment will not be processed without this documentation.

Are you enrolling in the Health Plan due to COVID-19 pandemic? Yes No

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security # (required):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
CAQH Provider ID (required):	Language(s) spoken other than English:	

Applying as: PCP Specialist Allied/Consulting Health Professional

Individual NPI #:	Group Name (If Applicable):	
Tax ID #:	Group Tax ID #:	Group NPI #:
Primary Specialty:	Taxonomy Code (required):	License # & State:
Second Specialty:	Taxonomy Code (required):	DEA # & State:
Medicaid # (required): To be enrolled in Medicaid products, an active Medicaid ID number is required	Medicare #:	

Select only one provider type:

Non-Credentialed

<input type="checkbox"/> Anesthesiologist *	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Locum Tenens	<input type="checkbox"/> CDE (affiliated with Physician Group or Hospital)
<input type="checkbox"/> CRNA	<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Pathologist	<input type="checkbox"/> RD (affiliated with Physician Group or Hospital)

Requested Effective Date: ____/____/____ (non-credentialed providers only—30-day backdate only)

[We will notify you when your application has been approved. Upon notification, you will be considered a participating provider in our network. Prior to receiving this notification, you are not considered in-network.]

If you selected Anesthesiologist*, Emergency Room, Hospitalist, Locum Tenens, Pathologist, CRNA, CDE or RD, you must complete the disclosure questions on the last page.

* Do you provide Pain Management? Yes No **If Yes, you must be credentialed.**

Credentialed

(Credentialed specialties are usually processed within 90 days of receipt.)

<input type="checkbox"/> Acupuncturist (LAC)	<input type="checkbox"/> Enterostomal Therapy	<input type="checkbox"/> Occupational Therapist (OT)
<input type="checkbox"/> Audiologist (AUD)	<input type="checkbox"/> Licensed Behavioral Analyst (ABA)	<input type="checkbox"/> Optometrist (OD)
<input type="checkbox"/> Certified Diabetic Educator (CDE) ¹	<input type="checkbox"/> Licensed Clinical Social Worker (LCSW)	<input type="checkbox"/> Oral Maxillofacial Surgery (DMD)
<input type="checkbox"/> Certified Nurse Midwife (CNM)	<input type="checkbox"/> Licensed Marriage & Family Therapist (LMFT)	<input type="checkbox"/> Osteopathic Doctor (DO)
<input type="checkbox"/> Certified Nurse Midwife—Home Birth (CNM)	<input type="checkbox"/> Licensed Mental Health Counselor (LMHC) ²	<input type="checkbox"/> Physical Therapist (PT)
<input type="checkbox"/> Clinical Psychologist (PHD/PSYD)	<input type="checkbox"/> Medical Doctor (e.g. MD/MBBS/BMED etc.)	<input type="checkbox"/> Registered Dietician (RD) ¹
<input type="checkbox"/> Doctor of Chiropractic (DC)	<input type="checkbox"/> Nurse Practitioner, Primary Care	<input type="checkbox"/> Speech Pathologist (SP/SLP)
<input type="checkbox"/> Doctor of Podiatric Medicine (DPM)	<input type="checkbox"/> Nurse Practitioner, Psychiatry	

¹ Independent ² Not facility based must complete page 4

Experienced HIV/AIDS Provider: Yes No

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

Address A	<input type="radio"/> Primary Office	<input type="radio"/> Additional Office	<input type="radio"/> Correspondence	<input type="radio"/> Remittance	<input type="radio"/> Medical Record	
	Address:			Ste:	City:	State: ZIP Code:
	Phone (required):			Fax:		
	Handicap accessible (required): <input type="checkbox"/> Yes <input type="checkbox"/> No			Public Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	List address in directory (required): <input type="checkbox"/> Yes <input type="checkbox"/> No			Provider is Hospitalist at this address: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address B	<input type="radio"/> Primary Office	<input type="radio"/> Additional Office	<input type="radio"/> Correspondence	<input type="radio"/> Remittance	<input type="radio"/> Medical Record	
	Address:			STE:	City:	State: ZIP Code:
	Phone (required):			Fax:		
	Handicap accessible (required): <input type="checkbox"/> Yes <input type="checkbox"/> No			Public Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	List address in directory (required): <input type="checkbox"/> Yes <input type="checkbox"/> No			Provider is Hospitalist at this address: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address C	<input type="radio"/> Primary Office	<input type="radio"/> Additional Office	<input type="radio"/> Correspondence	<input type="radio"/> Remittance	<input type="radio"/> Medical Record	
	Address:			STE:	City:	State: ZIP Code:
	Phone (required):			Fax:		
	Handicap accessible (required): <input type="checkbox"/> Yes <input type="checkbox"/> No			Public Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	List address in directory (required): <input type="checkbox"/> Yes <input type="checkbox"/> No			Provider is Hospitalist at this address: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Note: If you have already completed your application with CAQH, please ensure that you have authorized all applicable organizations to access your data. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with the health plan. If applicable, contact the health plan directly to request contracting information.

Application for Practitioner Enrollment

What hours are you available to see patients?

Location A:			Location B:			Location C:		
	Office Start	Office End		Office Start	Office End		Office Start	Office End
Monday			Monday			Monday		
Tuesday			Tuesday			Tuesday		
Wednesday			Wednesday			Wednesday		
Thursday			Thursday			Thursday		
Friday			Friday			Friday		
Saturday			Saturday			Saturday		
Sunday			Sunday			Sunday		

Have you, your agent, or managing employee ever been convicted of a crime relating to Medicare, Medicaid or any government health program or the furnishing of, or billing for, medical care, services, or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals? Yes No If Yes, please provide the following:
Name/Title, DOB, Address, SSN:

Office/Credentialing Contact Information		
Contact Name (please print or type):		
Street Address:		
City:	State:	Zip Code:
Office Phone:	Email address (please print or type):	

Include the completed form along with a copy of the W-9 and malpractice (liability) insurance, and mail, email, or fax to:

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

Disclosure Questions for Non-Credentialed Practitioners

All questions must be completed by the following practitioners:

Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens, Pathologist, CRNA,

[Certified Diabetic Educator and Registered Dietician affiliated with Physician Group or Hospital]

1. Yes No NA Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?
2. Yes No NA Have your clinical privileges or medical staff membership at any hospital or health care institution (either voluntarily or involuntarily) ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected), or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee or
3. Yes No NA Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations or health plans (including HMOs, PPOs, or provider organizations such as independent practice associations or private health organizations)?
4. Yes No NA Have your federal Drug Enforcement Administration and/or state controlled dangerous substances (CDS) certificates(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?
5. Yes No NA Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS-authorizing entities, education or training program, Medicare or Medicaid program, regulatory agency, or any other private, federal or state health program or been a defendant in any civil action that is reasonably related to your qualifications, competence, functions or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
6. Yes No NA To your knowledge, has information pertaining to you ever been reported to the National Practitioner Databank or Healthcare Integrity and Protection Data Bank?
7. Yes No NA Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?

For any "Yes" response, please provide a detailed explanation on a separate sheet.

"I hereby attest that the above information is true and accurate to the best of my knowledge."

Provider Signature: _____ Date: _____

Include the completed form along with a copy of the W-9 and malpractice (liability) insurance, and mail or fax to:

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Fax number:	716-857-4578