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

ENROLLMENT APPLICATION FOR CREDENTIALED PRACTITIONERS ONLY
REQUIRED DOCUMENT CHECKLIST

Please submit current copies of ALL of the documentation listed below.
Any missing or inaccurate information may result in the rejection of the application and delay the enrollment process.

☐	Application for Practitioner Enrollment • Complete all sections, including Social Security number and Taxonomy Code. • All addresses: Primary Office Remittance, Correspondence, Medical Records, Credentialing contact.
☐	A council for Affordable Quality Health Care (CAQH) number is required for Credentialing. 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.
☐	W-9 Request for Taxpayer Identification Number and Certification
☐	Proof of Malpractice (liability) insurance • Minimum amount of $1 million per occurrence and $3 million aggregate. **Ensure certificate has current effective date,** expiration date, and coverage amounts. *(exception Doula)*
☐	Behavioral Health (BH) Certification, *where applicable.*

In accordance with applicable NYS Public Health and Insurance Laws, applications are reviewed for credentialing within 60 days of receiving a completed application. A completed application includes a complete and accurate CAQH application, re-attested to within the last 90 days and includes all supporting documentation as required by the Health Plan.

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.

You will receive notification of your participation status. Providers are not considered in-network/participating until applications are approved. If approved, you will be advised that you are an in-network provider and provided with an effective date of participation.

Include the completed form along with a copy of the W-9 and malpractice (liability) insurance, and mail or fax to:	
Email	**UniveraPR@Univerahealthcare.com**
Fax number	1-716-857-4578
Address	Univera Healthcare, Attn: Provider Relations, 205 Park Club Lane, Buffalo, NY 14221

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Application for Practitioner Enrollment

This application is only used for participation with Univera Healthcare.
Copies of your licenses, malpractice (Liability) insurance, and W-9 must be attached.
Enrollment will not be processed without this documentation.
All fields are required to be completed.

By signing this application, I attest that I have reviewed the Health Plan's Credentialing Policies and Criteria and understand the eligibility requirements for my specialty. All criteria must be met prior to network participation.

Please visit Providers | Credentialing Policies | Univera Healthcare (univerahealthcare.com)

Applying as:	☐ PCP	☐ Specialist	☐ Allied/Consulting Health Professional

Last Name:	*First* Name:	Middle Initial:
Date of Birth:	Social Security #:	Gender: ☐ Female ☐ Male
Individual NPI #:	CAQH Provider ID *(required)*:	
Primary Specialty:	Taxonomy Code:	
Second Specialty:	Taxonomy Code:	
Experienced HIV/AIDS Provider ☐ Yes ☐ No		

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

Individual Tax ID #:	
Group Name *(if applicable)*:	
Group Tax ID #:	Group NPI(s) #:
License # & State:	DEA # & State:
Medicare #:	Medicaid #:
To be enrolled in Medicare products, an active Medicare ID number is required.	To be enrolled in Medicaid products, an active Medicaid ID number is required.

Proceed to Page 3 for additional required information.

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Select the provider type for which you wish to be Credentialed

For additional information regarding the credentialing process, please visit Join Our Network | Providers | Univera Healthcare (univerahealthcare.com)

In accordance with applicable NYS Public Health and Insurance Laws, applications are credentialed within 60 days of receiving a completed application. *Practitioners required to complete the Credentialing process will be provided an approval/effective date determined by the Health Plan.*

☐ Acupuncturist (LAC)	☐ Licensed Behavioral Analyst (ABA)	☐ Optometrist (OD)
☐ Audiologist (AUD) *Will you dispense hearing aids?* ☐ Yes ☐ No If YES, list taxonomy code: _____		
☐ Certified Diabetic Educator (CDE)[1]	☐ Licensed Creative Arts Therapist (LCAT)[2]	☐ Oral Maxillofacial Surgery (DMD)
☐ Certified Nurse Midwife (CNM)	☐ Licensed Clinical Social Worker (LCSW)	☐ Osteopathic Doctor (DO)
☐ Certified Nurse Midwife - Home Birth (CNM)	☐ Licensed Marriage & Family Therapist (LMFT)[2]	☐ Physical Therapist (PT)
☐ Clinical Psychologist (PHD/PSYD)	☐ Licensed Massage Therapists	☐ Radiologist including Tele-Radiologist
☐ Doctor of Chiropractic (DC)	☐ Licensed Mental Health Counselor (LMHC)	☐ Registered Dietitian (RD)[1]
☐ Doctor of Podiatric Medicine (DPM)	☐ Medical Doctor (MD/MBBS/BMED, etc.)	☐ Speech Pathologist (SP/SLP)
☐ Enterostornal Therapy	☐ Nurse Practitioner (NP)[1,3]	
☐ Genetic Counselor (MS)	☐ Occupational Therapist (OT)	

[1] Independently Practicing
[2] All LCATs and LMFTs attest to having over 6 years of post-graduate clinical experience, prior to credentialing.
[3] Nurse Practitioners licensed in Acute Care, Geronotololgy, Neonatology, Oncology, Psychiatry and Women's Health will be credentialed as specialists. Nurse Practitioners licensed in Adult Medicine, Family Medicine and Pediatrics will be credentialed as Primary Care Practitioners.

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 moral?

☐ Yes ☐ No If Yes,please provide the following: Name/Title, DOB, Address, SSN:

By checking this box you are opting-in to receiving e-alerts & correspondence via email Provider email address will need to be provided ☐	Provider's Email Address *(please type or print):*
Office/Credentialing Contact name (Please print or type):	
Office/Credentialing Contact email address (Please print or type):	
Office/Credentialing Contact phone number (Please print or type):	
I hereby attest that the above information is true and accurate to the best of my knowledge.	
Practitioner's signature *(required)* _____	Date:

Proceed to Page 4 for address information.

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Application for Practitioner Enrollment

All fields within each section must be completed, if being used.

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

☐ Primary Address ☐ Additional Address ☐ Remittance ☐ Correspondence ☐ Medical Record

Address: Ste: City State: Zip Code:

Phone: Fax: Is this address Handicap accessible? ☐ Yes ☐ No

Is this address used for "Telehealth services." ☐ Yes ☐ No

Are patients able to schedule an appointment at this location? ☐ Yes ☐ No

Hours available to see patients* Mon ___-___ Tues ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___

Address B

☐ Primary Address ☐ Additional Address ☐ Remittance ☐ Correspondence ☐ Medical Record

Address: Ste: City State: Zip Code:

Phone: Fax: Is this address Handicap accessible? ☐ Yes ☐ No

Is this address used for "Telehealth services." ☐ Yes ☐ No

Are patients able to schedule an appointment at this location? ☐ Yes ☐ No

Hours available to see patients* Mon ___-___ Tues ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___

Address C

☐ Primary Address ☐ Additional Address ☐ Remittance ☐ Correspondence ☐ Medical Record

Address: Ste: City State: Zip Code:

Phone: Fax: Is this address Handicap accessible? ☐ Yes ☐ No

Is this address used for "Telehealth services." ☐ Yes ☐ No

Are patients able to schedule an appointment at this location? ☐ Yes ☐ No

Hours available to see patients* Mon ___-___ Tues ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___

Address D

☐ Primary Address ☐ Additional Address ☐ Remittance ☐ Correspondence ☐ Medical Record

Address: Ste: City State: Zip Code:

Phone: Fax: Is this address Handicap accessible? ☐ Yes ☐ No

Is this address used for "Telehealth services." ☐ Yes ☐ No

Are patients able to schedule an appointment at this location? ☐ Yes ☐ No

Hours available to see patients* Mon ___-___ Tues ___-___ Wed ___-___ Thu ___-___ Fri ___-___ Sat ___-___ Sun ___-___

If there are additional locations that exceed this page, include an additional page with the required information for each location.

◊ Is this address Handicap Accessible? ◊ Are patients able to schedule an appointment at this location?

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

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BEHAVIORAL HEALTH PROVIDERS (BH) Certification

CONVERSION THERAPY

I _____ attest to the following;
[First Name, Middle Initial, Last Name]

☐	I am a mental health professional participating/seeking to participate in the Univera Healthcare provider network.
☐	I will not provide conversion therapy to minors who are Univera Healthcare members and I will not seek reimbursement from Univera Healthcare for such services.
☐	I understand that "conversion therapy" is defined as "any practice by a mental health professional that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feeling toward individuals of the same sex."
☐	I will comply with all other applicable laws, rules, regulations and Univera Healthcare policies regarding conversion therapy.

Print Name: _____ Date: _____

Signature: _____

Include the completed form along with a copy of the W-9 and malpractice (liability) insurance and mail or fax to::	
Email	**UniveraPR@Univerahealthcare.com**
Fax Number:	1-716-857-4578
Address:	Univera Healthcare, Attn: Provider Relations, 205 Park Club Lane, Buffalo, NY 14221

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