univera HEALTHCARE an excellus company

Application for Health Coach

To begin the enrollment process, or update demographics, please complete all fields that are applicable.
A copy of the Medicare Certification form, Medicaid Certification form, W9 and Malpractice Insurance must be attached.
Applicant and Program Director must sign the attestation fields.
Mail to: Univera Healthcare, Attn: Provider Relations, 205 Park Club Lane, Buffalo, NY 14221 or fax to: 716-857-4578

This is a: First-time application ☐ OR Demographic change ☐	Effective Date of Registration:
Group Name:	
Group NPI #:	Billing Tax ID #:

Last Name:	First Name:	Middle Initial:
Date of Birth:	Gender: ☐ Male ☐ Female	Individual NPI #:
Social Security # (***required***):	Taxonomy Code (***required***): **174H00000X**	
Office Contact Name and Phone ***(Please print or type):***		
Office Contact Email ***(Please print or type):***		

Office addresses ***must*** be identified by street level information with the corresponding City, State and ZIP Code. PO BOX information is ***not*** allowed.

Primary Office Address:			STE:
City:	County:	State:	ZIP Code:
Phone ***(required):***	Fax:		
Is this office Handicap accessible (***required***): ☐ Yes ☐ No		Public Transportation: ☐ Yes ☐ No	

Additional Office Address:			STE:
City:	County:	State:	ZIP Code:
Phone ***(required):***	Fax:		
Is this office Handicap accessible (***required***): ☐ Yes ☐ No		Public Transportation: ☐ Yes ☐ No	

Please provide only **ONE** Correspondence, **ONE** Remittance, and **ONE** Medical Records address. 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.

Correspondence Address:			STE:
City:		State:	ZIP Code:
Phone:	Fax:		
Remittance Address:			STE:
City:		State:	ZIP Code:
Phone:	Fax:		
Medical Record Address:			STE:
City:		State:	ZIP Code:
Phone:	Fax:		

APPLICANT ATTESTATION: I, the undersigned, hereby attest that the above information is true and accurate to the best of my knowledge.

Applicant Name (signature):	Date:

PROGRAM DIRECTOR ATTESTATION: I, the undersigned, hereby attest that the above applicant has been certified by CMS and that the information and the certification provided is true and accurate to the best of my knowledge.

Program Director Name (print):	Date:
Program Director Name (signature):	