

Requested Effective Date
This is a: First-time application <input type="checkbox"/> OR Demographic change <input type="checkbox"/>
<i>Please check here if this request is for temporary participation with the health plan during the COVID-19 Pandemic.</i> <input type="checkbox"/>
<small>Providers requesting enrollment due to the COVID-19 Pandemic will not be credentialed with the plan. Upon the expiration of the applicable Executive Orders (EO), on which your temporary participation was approved, you will be required to meet all of our network requirements, including our contracting, credentialing and enrollment criteria, for continued participation in our network.</small>

Group Name:	
Group NPI #:	Billing Tax ID #:

Last Name:	First Name:	Middle Initial:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security # (<i>required</i>):	Individual NPI #:	
Taxonomy Code (<i>required</i>): 174H00000X		
Medicare #:	Medicaid #:	To be enrolled in Medicaid products, an <i>active</i> Medicaid ID number is required.

Office Contact Name (<i>Please print or type</i>):
Office Contact Phone (<i>Please print or type</i>):
Office Contact Email (<i>Please print or type</i>):

Race/Ethnicity— <i>for reporting purposes only.</i>	
American Indian or Alaskan Native (Not Hispanic or Latino) <input type="checkbox"/>	Other <input type="checkbox"/>
Asian (Not Hispanic or Latino) <input type="checkbox"/>	Prefer Not to Say <input type="checkbox"/>
Black or African American (Not Hispanic or Latino) <input type="checkbox"/>	Two or More Races (Not Hispanic or Latino) <input type="checkbox"/>
Hispanic or Latino <input type="checkbox"/>	White/Caucasian (Not Hispanic or Latino) <input type="checkbox"/>
Native Hawaiian or other Pacific Island (Not Hispanic or Latino) <input type="checkbox"/>	

Proceed to Page 2 for address information.

Application for Health Coach

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 <i>(required)</i> :		Fax:	
Is this office Handicap accessible <i>(required)</i> : <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this address used for Telehealth services <i>(required)</i> : <input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional Address:			STE:
City:	County:	State:	ZIP Code:
Phone <i>(required)</i> :		Fax:	
Is this office Handicap accessible <i>(required)</i> : <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this address used for Telehealth services <i>(required)</i> : <input type="checkbox"/> Yes <input type="checkbox"/> 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 <i>(required)</i> :	Date:
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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 <i>(required)</i> :	

Submit the completed application, a copy of the Medicare and Medicaid Certification forms, W9, and malpractice insurance to us using one of the methods below.

Email: UniveraPR@Univerahealthcare.com

Fax: 716-857-4578

Mail: Univera Healthcare, Attn: Provider Relations, 205 Park Club Lane, Buffalo, NY 14221