univera HEALTHCARE

Application for Non-Physician Health Care Practitioner

To begin the enrollment process, or update demographics, please complete all information and fax it to 1-716-857-4578 or mail to: Provider Relations, 205 Park Club Lane, Buffalo, NY 14221-5239. Copies of your diploma, licenses, malpractice (liability) insurance, and W-9 must be attached. Enrollment will not be processed without this documentation.

Is this application due to COVID-19 pandemic? ☐ *Yes* ☐ *No*

This is a: First-time application ☐	Demographic change ☐	Sponsor change ☐	Effective Date of Registration:

Nurse Practitioner ☐ Registered Nurse First Assistant ☐ Physician Assistant ☐ Certified Behavior Analyst Assistant ☐

Last Name:	First Name:	Middle Initial:
Individual NPI #:	Date of Birth:	Gender: ☐ Male ☐ Female
Taxonomy Code *(required):*	License #/State :	Medicare #:
Language(s) other than English:	DEA Certificate #:	***To be enrolled in Medicaid products, an *active* Medicaid ID is required.**
Social Security # (*required*):	***Medicaid # (*required):***	

Collaborating Physician Name:	Specialty:
Collaborating Physician NPI #:	Group NPI #:
Medical Practice Group Name:	Billing Tax ID #:

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:	State:	Zip Code:	County:
Phone ***(required)*** :	Fax:	Public Transportation: ☐ Yes ☐ No	
Handicap accessible (*required*): ☐ Yes ☐ No			

Additional Office Address:			STE:
City:	State:	Zip Code:	County:
Phone ***(required)*** :	Fax:	Public Transportation: ☐ Yes ☐ No	
Handicap accessible (*required*): ☐ 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:	Email:	

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:

COLLABORATING PHYSICIAN ATTESTATION: I, the undersigned, hereby verify and attest that I am the collaborating physician for the above-named applicant. As required by applicable laws, I have satisfied myself as to the ability and competency of this applicant and that the functions that the applicant will carry out are performed under my collaboration and oversight. (If additional collaborating physician signatures are required, please attach additional signatures of attestation to this form.)

Collaborating Physician Name (print):	Date:
Collaborating Physician Name (signature):	

Office Contact Name/Phone ***(please type or print):***

Office Contact Email ***(please type or print):***