

ENROLLMENT APPLICATION NON CRED ONLY REQUIRED DOCUMENT 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 including Social Security number and Taxonomy Code. • All addresses: Primary Office Remittance, Correspondence, Medical Records.
<input type="checkbox"/>	W-9 Request for Taxpayer Identification Number and Certification
<input type="checkbox"/>	<p>Proof of Malpractice (liability) insurance</p> <ul style="list-style-type: none"> • Minimum amount of \$1 million per occurrence and \$3 million aggregate. Ensure certificate has current effective date, expiration date, and coverage amounts.
<input type="checkbox"/>	Doula Only. 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.
<input type="checkbox"/>	Disclosure Questions for Non-Credentialed Practitioners

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



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 must be completed.

By signing this application, I attest to not providing Telehealth only services and understand that I must maintain a physical practice location within the Health Plan's geographic service area to be considered for an in network participation.

Applying as:	<input type="checkbox"/> PCP	<input type="checkbox"/> Specialist	<input type="checkbox"/> Allied/Consulting Health Professional
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Last Name:	First Name:	Middle Initial:
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Date of Birth:	Social Security #:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
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Individual NPI #:	CAQH Provider ID:
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Primary Specilaty:	Taxonomy Code:
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Second Specilaty:	Taxonomy Code:
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Experienced HIV/AIDS Provider <input type="checkbox"/> Yes <input type="checkbox"/> No
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What language(s) are you fluent in when speaking about medical care? *Check all that apply.*

<input type="checkbox"/> Arabic	<input type="checkbox"/> ASL	<input type="checkbox"/> English	<input type="checkbox"/> French
<input type="checkbox"/> Mandarin	<input type="checkbox"/> Nepali	<input type="checkbox"/> Russian	<input type="checkbox"/> Somali
<input type="checkbox"/> Spanish	<input type="checkbox"/> Ukrainian	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other:

What language services are available at your location? *Check all that apply.*

<input type="checkbox"/> Bi-Lingual Staff	<input type="checkbox"/> On Site Interpreter
<input type="checkbox"/> Remote Interpreter - Audio	<input type="checkbox"/> Remote Interpreter - Video

Race - to be shared with members upon request

<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Other
<input type="checkbox"/> Asian	<input type="checkbox"/> Prefer Not to Say
<input type="checkbox"/> Black or African American	<input type="checkbox"/> White
<input type="checkbox"/> Native Hawaiian or other Pacific Island	

Ethnicity - to be shared with members upon request

<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Prefer Not to Say
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Individual Tax ID #:

Group Name (if applicable):

Group Tax ID #:	Group NPI(s) #:
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License # & State:	DEA # & State:
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Medicare #: To be enrolled in Medicare products, an active Medicare ID number is required.	Medicaid #: To be enrolled in Medicaid products, an active Medicaid ID number is required.
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Non Credentialed (Select one provider type)

Requested Effective Date: _____ Non-credentialed providers will receive a **30-day backdate** only.

<input type="checkbox"/> Anesthesiologist	Do you provide Pain Management? * <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, you must be credentialed and complete Credentialed Practitioner form.
<input type="checkbox"/> Certified Diabetic Educator (affiliated with Physician Group or Hospital)	<input type="checkbox"/> Hospitalist (a dedicated in-patient physician who works exclusively in a hospital)	
<input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA)	<input type="checkbox"/> Locum Tenens	<input type="checkbox"/> Registered Dietitian (RD) (affiliated with Physician Group or Hospital)
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Pathologist	<input type="checkbox"/> Doula

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 Contact name (Please print or type): _____

Office Contact email address (Please print or type): _____

Office 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: _____

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	<input type="checkbox"/> Primary Address	<input type="checkbox"/> Additional Address	<input type="checkbox"/> Remittance	<input type="checkbox"/> Correspondence	<input type="checkbox"/> Medical Record
Address:		Ste:	City	State:	Zip Code:
Phone:	Fax:		Is this address Handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is this address used for "Telehealth services." <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider Hospitalist at this address <input type="checkbox"/> Yes <input type="checkbox"/> No			
Hours available to see patients					
Mon	Tues	Wed	Thu	Fri	Sat Sun

Address B	<input type="checkbox"/> Primary Address	<input type="checkbox"/> Additional Address	<input type="checkbox"/> Remittance	<input type="checkbox"/> Correspondence	<input type="checkbox"/> Medical Record
Address:		Ste:	City	State:	Zip Code:
Phone:	Fax:		Is this address Handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is this address used for "Telehealth services." <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider Hospitalist at this address <input type="checkbox"/> Yes <input type="checkbox"/> No			
Hours available to see patients					
Mon	Tues	Wed	Thu	Fri	Sat Sun

Address C	<input type="checkbox"/> Primary Address	<input type="checkbox"/> Additional Address	<input type="checkbox"/> Remittance	<input type="checkbox"/> Correspondence	<input type="checkbox"/> Medical Record
Address:		Ste:	City	State:	Zip Code:
Phone:	Fax:		Is this address Handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is this address used for "Telehealth services." <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider Hospitalist at this address <input type="checkbox"/> Yes <input type="checkbox"/> No			
Hours available to see patients					
Mon	Tues	Wed	Thu	Fri	Sat Sun

Address D	<input type="checkbox"/> Primary Address	<input type="checkbox"/> Additional Address	<input type="checkbox"/> Remittance	<input type="checkbox"/> Correspondence	<input type="checkbox"/> Medical Record
Address:		Ste:	City	State:	Zip Code:
Phone:	Fax:		Is this address Handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is this address used for "Telehealth services." <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider Hospitalist at this address <input type="checkbox"/> Yes <input type="checkbox"/> 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.

**All questions *must* be completed by the following practitioners:
Anesthesiologist, Emergency Room, Hospitalist, Locum Tenens, Pathologist, CRNA, Doula
[Certified Diabetic Educator and Registered Dietitian affiliated with Physician Group or Hospital]**

1.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	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 governing board?
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Have your federal Drug Enforcement Administration and/or state controlled dangerous substances (CDS) certifications(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	To your knowledge, has information pertaining to you ever been reported to the National Practitioner Databank or Healthcare Integrity and Protection Data Bank?
7.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	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.
Failure to provide a detailed explanation will delay the enrollment process.***

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

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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