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

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.

☐	Application for Practitioner Enrollment • Complete all sections including Social Security number and Taxonomy Code. • All addresses: Primary Office Remittance, Correspondence, Medical Records.
☐	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)*
☐	**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.
☐	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	**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 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:	☐ 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:	
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 #: 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.*	
☐ Anesthesiologist *Do you provide Pain Management? ** ☐ Yes ☐ No	If Yes, you must be credentialed and complete Credentialed Practitioner form.	
☐ Certified Diabetic Educator (affiliated with Physician Group or Hospital)	☐ Hospitalist (a dedicated in-patient physician who works exclusively in a hospital)	
☐ Certified Registered Nurse Anesthetist (CRNA)	☐ Locum Tenens	☐ Registered Dietitian (RD) (affiliated with Physician Group or Hospital)
☐ Emergency Medicine	☐ Pathologist	☐ 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:	

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	Provider Hospitalist at this address ☐ 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	Provider Hospitalist at this address ☐ 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	Provider Hospitalist at this address ☐ 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	Provider Hospitalist at this address ☐ 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.

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Disclosure Questions for Non-Credentialed Practitioners

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.	☐ Yes ☐ No ☐ 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.	☐ Yes ☐ No ☐ 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.	☐ Yes ☐ No ☐ 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.	☐ Yes ☐ No ☐ 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.	☐ Yes ☐ No ☐ 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.	☐ Yes ☐ No ☐ 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.	☐ Yes ☐ No ☐ 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::

Email	**UniveraPR@Univerahealthcare.com**
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