

Application for Non-Physician Health Care Practitioner

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.

Requested Effective Date:				
Request type:	<input type="checkbox"/> First-time application	<input type="checkbox"/> Join a new tax ID	<input type="checkbox"/> Demographic change	<input type="checkbox"/> Sponsor change
Applying as:	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Registered Nurse First Assistant	
<input type="checkbox"/> Certified Behavior Analyst Assistant	<input type="checkbox"/> Licensed Master Social Worker (LMSW)	<input type="checkbox"/> Licensed Creative Arts Therapist (LCAT)	<input type="checkbox"/> Psychoanalyst	
Last Name:		First Name:		Middle Initial:
Date of Birth:		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Social Security #:		Individual NPI #:		CAQH Provider ID:
Non-Physician Taxonomy Code:		Specialty:		
License #:		License State:		
DEA Certification #:		DEA Certification State:		
Medicare #: <small>To be enrolled in Medicare products, an active Medicare ID is required (does not apply to Psychoanalysts, LMSW or LCAT).</small>		Medicaid #: <small>To be enrolled in Medicaid products, an active Medicaid ID is required (does not apply to Psychoanalysts, LMSW or LCAT).</small>		
What language(s) are you fluent in when speaking about medical care? <i>Check all that apply.</i>				
<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? <i>Check all that apply.</i>				
<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
<input type="checkbox"/> "I attest that I have completed 3,600 hours of experience as a licensed or certified NP 1-in accordance with the laws of New York or another state or 2-while employed by the United States veteran's administration, armed forces or public health service. Therefore, I do not require a collaborating provider." If yes, please leave the Collaborating Physician fields blank but include Group Name, Group NPI, Group Tax ID and Specialty.				
Collaborating Physician Name:				
Collaborating Physician NPI #:				
Group Name:		Group NPI #:		
Tax ID #:		Specialty:		

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

Primary Address:			Ste:
City:	State:	Zip Code:	
Phone:	Fax:		
Is this address used for "Telehealth services." <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this address Handicap Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional Address:			Ste:
City:	State:	Zip Code:	
Phone:	Fax:		
Is this address used for "Telehealth services." <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this address Handicap Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Correspondence Address:			Ste:
City:	State:	Zip Code:	
Phone:	Fax:		

Medical Record Address:			Ste:
City:	State:	Zip Code:	
Phone:	Fax:		

Remittance Address:			Ste:
City:	State:	Zip Code:	
Phone:	Fax:		

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

Applicant Name (signature):	Date:
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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.

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

Office Contact Name & Phone:

Office Contact Email:

Submit the completed application, diploma, licenses, malpractice (liability) insurance and W9 to us using one of the methods below. Psychoanalysts, LMSWs and LCATs must also include a copy of the collaborating physician's license.

Email: UniveraPR@UniveraHealthcare.com

Fax: 1-716-857-4578

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