

ENROLLMENT APPLICATION FOR CREDENTIALLED PRACTITIONERS ONLY REQUIRED DOCUMENT CHECKLIST

Please submit current copies of ALL of the documentation listed below.

Any missing or inaccurate information may result in the rejection of the application and delay the enrollment process.

<input type="checkbox"/>	Application for Practitioner Enrollment <ul style="list-style-type: none"> • Complete all sections, including Social Security number and Taxonomy Code. • All addresses: Primary Office Remittance, Correspondence, Medical Records, Credentialing contact.
<input type="checkbox"/>	A council for Affordable Quality Health Care (CAQH) number is required for Credentialing. You can self-register on the CAQH website (www.caqh.org). Please ensure that your CAQH information is completed and released to us with the most up-to-date information.
<input type="checkbox"/>	W-9 Request for Taxpayer Identification Number and Certification
<input type="checkbox"/>	Proof of Malpractice (liability) insurance <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. <i>(exception Doula)</i>
<input type="checkbox"/>	Behavioral Health (BH) Certification, <i>where applicable</i> .

In accordance with applicable NYS Public Health and Insurance Laws, applications are reviewed for credentialing within 60 days of receiving a completed application. A completed application includes a complete and accurate CAQH application, re-attested to within the last 90 days and includes all supporting documentation as required by the Health Plan.

If you have already completed your application with CAQH, please ensure that you have authorized all applicable organizations to access your data. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with the Health Plan. If applicable, contact the Health Plan directly to request contracting information.

You will receive notification of your participation status. Providers are not considered in-network/participating until applications are approved. If approved, you will be advised that you are an in-network provider and provided with an effective date of participation.

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



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 are required to be completed.

By signing this application, I attest that I have reviewed the Health Plan's Credentialing Policies and Criteria and understand the eligibility requirements for my specialty. All criteria must be met prior to network participation.

Please visit [Providers | Credentialing Policies | Univera Healthcare \(univerahealthcare.com\)](#)

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 (required):
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Primary Specialty:	Taxonomy Code:
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Second Specialty:	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 #:	Medicaid #:
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To be enrolled in Medicare products, an active Medicare ID number is required.	To be enrolled in Medicaid products, an active Medicaid ID number is required.
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Proceed to Page 3 for additional required information.

Select the provider type for which you wish to be Credentialed

For additional information regarding the credentialing process, please visit [Join Our Network | Providers | Univera Healthcare](#) (univerahealthcare.com)

In accordance with applicable NYS Public Health and Insurance Laws, applications are credentialed within 60 days of receiving a completed application.
Practitioners required to complete the Credentialing process will be provided an approval/effective date determined by the Health Plan.

<input type="checkbox"/> Acupuncturist (LAC)	<input type="checkbox"/> Genetic Counselor (MS)	<input type="checkbox"/> Occupational Therapist (OT)
<input type="checkbox"/> Audiologist (AUD) Will you dispense hearing aids? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, list taxonomy code: _____		
<input type="checkbox"/> Certified Diabetic Educator (CDE) ¹	<input type="checkbox"/> Licensed Behavioral Analyst (ABA)	<input type="checkbox"/> Optometrist (OD)
<input type="checkbox"/> Certified Nurse Midwife (CNM)	<input type="checkbox"/> Licensed Clinical Social Worker (LCSW)	<input type="checkbox"/> Oral Maxillofacial Surgery (DMD)
<input type="checkbox"/> Certified Nurse Midwife - Home Birth (CNM)	<input type="checkbox"/> Licensed Marriage & Family Therapist (LMFT) ²	<input type="checkbox"/> Osteopathic Doctor (DO)
<input type="checkbox"/> Clinical Psychologist (PHD/PSYD)	<input type="checkbox"/> Licensed Mental Health Counselor (LMHC) ²	<input type="checkbox"/> Physical Therapist (PT)
<input type="checkbox"/> Doctor of Chiropractic (DC)	<input type="checkbox"/> Medical Doctor (MD/MBBS/BMED, etc.)	<input type="checkbox"/> Radiologist including Tele-Radiologist
<input type="checkbox"/> Doctor of Podiatric Medicine (DPM)	<input type="checkbox"/> Nurse Practitioner (NP) ^{1,3}	<input type="checkbox"/> Registered Dietitian (RD) ¹
<input type="checkbox"/> Enterostomal Therapy		<input type="checkbox"/> Speech Pathologist (SP/SLP)

¹ Independently Practicing

² All LMFT's attest to having over 6 years of post-graduate clinical experience, prior to credentialing.

³ Nurse Practitioners licensed in Acute Care, Gerontology, Neonatology, Oncology, Psychiatry and Women's Health will be credentialed as specialists. Nurse Practitioners licensed in Adult Medicine, Family Medicine and Pediatrics will be credentialed as Primary Care Practitioners.

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/Credentialing Contact name (Please print or type):

Office/Credentialing Contact email address (Please print or type):

Office/Credentialing 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.

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			Are patients able to schedule an appointment at this location? <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			Are patients able to schedule an appointment at this location? <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			Are patients able to schedule an appointment at this location? <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			Are patients able to schedule an appointment at this location? <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.

◇ Is this address Handicap Accessible? ◇ Are patients able to schedule an appointment at this location?

*If Primary Care Physician (PCP), office hours required

I _____ attest to the following;
[First Name, Middle Initial, Last Name]

I am a mental health professional participating/seeking to participate in the Univera Healthcare provider network.

I will not provide conversion therapy to minors who are Univera Healthcare members and I will not seek reimbursement from Univera Healthcare for such services.

I understand that "conversion therapy" is defined as "any practice by a mental health professional that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feeling toward individuals of the same sex."

I will comply with all other applicable laws, rules, regulations and Univera Healthcare policies regarding conversion therapy.

Print Name: _____ Date: _____

Signature: _____

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