Initial Practitioner Information Form

To begin your enrollment process, please use this simple, standardized form. Please complete all information as it applies to your specialty. Information that does not apply to your specialty may be left blank.

DATE:		
Last Name:	First Name:	Middle Initial:
Date of Birth:	Gender: ☐ Male ☐ Female	
Primary Telephone No.: ( ) -	Primary Fax No.: ( ) -	
Primary Office Street Address:		Suite #:
Primary Office City:	State: / County:	Zip: -
Email Address:		
Social Security No.:	DEA Certificate No.:	
State License No.:	Licensed State:	
UPIN (if applicable):	Tax ID:	Group Tax ID:
Provider Type (MD, DO, DC, DDS, DMD, DPM, etc) :		
Specialty:	Applying As: ☐ PCP ☐ Specialist ☐ Allied/Consulting Health Professional	
Are you board certified? ☐ Yes ☐ No	If Yes, board name:	
Are you registered with CAQH? ☐Yes ☐No	If Yes, CAQH Provider ID:	
NPI number:	Group NPI Number: Other NPI Number:	
Taxonomy Code:		
Name of Group or Employer (if applicable): Group Number: Effective date of group affiliation:		
Is Main Office Address Handicap accessible?	☐Yes ☐ No	

Second Office Address (if applicable):	
Street Address:	
City:	County:
State:	Zip Code: -
Office Phone: ( ) - ext.	Office Fax: ( ) -
Is Second Office Address Handicap accessible?	☐ Yes ☐ No

Billing Address:	
Street Address:	
City:	County:
State:	Zip Code: -
Phone: ( ) - ext.	Fax: ( ) -

Medicare No.:		Worker's Comp No.:	
Medicaid No.:		CLIA Cert No.:	

What languages other than English do you speak?	

Hospital affiliations:

Hospital Name	**Hospital Address**

Office Contact Person:

Name: Phone: ( ) - ext.

Note: 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 any of the above organizations. If applicable, please contact the health plan directly to request contracting information.

Signature of person completing form: ____

Title: ____ Date: ______________________

PLEASE ATTACH W-9 FORM, COPY OF LICENSE, AND A COPY OF AGREEMENT SIGNATURE PAGE WITH THIS INFORMATION. ENROLLMENT WILL NOT BE PROCESSED WITHOUT THIS DOCUMENTATION.

Please return this form by mail or fax to the applicable **Network Management office**:

Buffalo: Univera Healthcare, Attn: Provider Relations
Address: 205 Park Club Lane, Buffalo, NY 14221
Phone: Contact your assigned Provider Relations Representative
Fax: 716-857-4578