

Provider Information Update Form

Instructions: Please complete this form and return by mail or fax to the addresses shown on the last page. This form must be personally signed by the provider (no signature stamps can be accepted).

- 1) Provider Name: _____
- 2) Provider's Tax ID Number: _____ individual number group number
 If this is a group number, what is the name of the group? _____
- 3) Provider's License Number: _____ State Issued _____
- 4) NPI (National Provider Identifier) Number(s) for:
 - Individual Provider NPI (Type 1): _____
 - Group – Entity NPI (Type 2): _____ Group Name: _____
 - Group – Entity NPI (Type 2): _____ Group Name: _____
- 5) Taxonomy Code for:
 - Primary Specialty: _____ Taxonomy Code: _____
 - Second Specialty: _____ Taxonomy Code: _____
 - Third Specialty: _____ Taxonomy Code: _____

*****For the remaining questions, fill out only the ones that require a change or update to your information *****

- 6) Address Change: *(please check appropriate box)*
 - Address/telephone change
 - Street Address _____
 - Suite/Bldg # _____
 - City _____
 - State _____ Zip Code _____ County _____
 - Phone () _____ Fax () _____
 - Termination date of location/telephone _____
 - Additional location/telephone
 - Street Address _____
 - Suite/Bldg # _____
 - City _____
 - State _____ Zip Code _____ County _____
 - Phone () _____ Fax () _____
 - Termination date of location/telephone _____
 - Terminating location/telephone
 - Street Address _____
 - Suite/Bldg # _____
 - City _____
 - State _____ Zip Code _____ County _____
 - Phone () _____ Fax () _____
 - Termination date of location/telephone _____
 - Billing Address/Telephone change
 - Effective date of new address _____
 - Email: Office _____ Physician _____
 - Handicap accessible? Yes No
 - Accessible to public transportation? Yes No
- Old Address: *(if address change checked)*
- Street Address _____
 - Suite/Bldg # _____
 - City _____
 - State _____ Zip Code _____ County _____
 - Phone () _____ Fax () _____
 - Email: Office _____ Physician _____

7) Is the tax ID listed above a change? Yes No *(If yes, attach a copy of W-9 Form – Paper only)*

Effective date of new tax ID # _____ What is the Old tax ID # _____

8) What hours are you available to see patients? *(For more than 2 locations, please attach an additional sheet – Paper only)*

Location 1: _____ Location 2: _____

	Office Start	Office End	Office Start	Office End
Monday			Monday	
Tuesday			Tuesday	
Wednesday			Wednesday	
Thursday			Thursday	
Friday			Friday	
Saturday			Saturday	
Sunday			Sunday	

9) Are you accepting new patients? Yes No

10) For Primary Care Physicians Only – List names of on-call physicians below *(attach additional sheet if necessary – Paper only)*

Name	Effective Date	Cross Cover?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

11) What languages are spoken by practitioners and clinical personnel in this office?

12) Hospital affiliations:

Hospital Name	Hospital Address

13) Do you have a nurse practitioner or physician's assistant who works with you? Yes No If yes, please list below.

Name	NP or PA	Effective Date
	<input type="checkbox"/> NP <input type="checkbox"/> PA	
	<input type="checkbox"/> NP <input type="checkbox"/> PA	
	<input type="checkbox"/> NP <input type="checkbox"/> PA	
	<input type="checkbox"/> NP <input type="checkbox"/> PA	

14) Additional comments:

Practitioner's signature required _____ Date _____
(stamps not acceptable)

Please fax, e-mail or mail this signed form to:

Fax: (800) 915-4574
E-mail: wny.provfile@univerahealthcare.com

Mail: Univera Healthcare
Provider File Maintenance
205 Park Club Lane
Buffalo, New York 14221