Registration Form for Non-Credentialed Providers

Provider Name:

Date of Birth: SSN: ❑ Male ❑ Female

Provider Type: ❑ Emergency Room ❑ Hospitalist ❑ Pathologist ❑ CRNA ❑ Anesthesiologist

NYS License/ Registration No.: DEA Certificate No.: *(as applicable)*

Hospital Affiliations *(as applicable):*

Name of Graduate School: Year Graduated:

Malpractice Insurance Policyholder: ❑ Self ❑ Facility ❑ Other

Payment Information

Federal Tax ID Number: NPI: Billing Contact Name:

Checks To Be Made Payable to: Phone #: Fax #:

Payment Address:

Service Address Information

Primary Service Address	Additional Service Address
Practice Name:	Practice Name:
Address:	Address:
Contact Name:	Contact Name:
Phone:	Phone:
Fax:	Fax:

Provider Signature

Signature: Date:

MAIL
OR
FAX:

- Completed form and contracts
- Copy of NYS Registration/License and W9
- Copy of malpractice certificate
- If applicable, a copy of DEA license

TO: Univera Healthcare Provider Relations
205 Park Club Lane
Buffalo, NY 14221
(716) 857-4578 (fax)

For Health Plan Use Only

NYS Registration Verified? ❑ Yes ❑ No

Malpractice Certificate Verified? ❑ Yes ❑ No

Approved By: Date: