Provider Application Form

The *Provider Application Form* must be completed in full and received by UniCare Health Plan of West Virginia, Inc. (UniCare) to begin the contracting and credentialing/verification process. If it is not completed in full, this application will be returned, and the contracting and credentialing/verification process will be delayed.

Practice identification (required)		
Legal business name:		
Doing business as (if applicable):		
Address:		City:
State:	ZIP:	County:
Phone:	Fax:	Website:
Primary contact:		
Phone:	Email:	

Section one: Provider detail (required)
Provider/physician's name:
Professional designation:
Specialty applying for:
Contract type applying for: ☐Medicaid only ☐WVCHIP only ☐Both
Choose one: ☐PCP ☐Specialist ☐Hospitalist ☐ Peer support specialist
Patient age range (Only applicable for PCP providers):
Note: By choosing PCP, the provider agrees to accept UniCare member assignments and be the main point of contact in coordinating and managing the member's healthcare. If not willing to accept member assignments, please choose specialist. If choosing **peer support specialist**, please include current West Virginia Certification Board for Addiction & Prevention Professionals (WVCBAPP) certification
TIN/EIN:

NPI (individual):	NPI (billing):
License number:	Date employment began:

Have you completed cultural competency training? ☐ Yes ☐ No

Section two: Council for Affordable Quality Healthcare (CAQH) detail (required)
Have you already completed a *CAQH On-Line Application*: ☐ Yes ☐ No
CAQH number:

Does your application include your current information: ☐ Yes ☐ No
- If *yes*, date of last attestation: _____/_____/_____.
Updates and *Attestation* must be current within the last 120 days. An expired attestation will delay processing of your application.
- If *no*, CAQH updates must be completed before submitting form for processing.
- If you have not selected **Global Authorization**, you will need to update your *CAQH On-Line Application* by logging in to your application and selecting **UniCare** as a plan authorized to access your data.

Section 3 — West Virginia (WV) Medicaid enrollment (required)

Are you enrolled with WV Medicaid: ☐ Yes   ☐ No
You must be an enrolled WV Medicaid provider to begin the UniCare contracting and credentialing process.

Section 4 — Provider remittance advice address (required)

Street address line 1:

Street address line 2:

City:	State:	ZIP:

Section 5 — Provider physical practice address(es) (required).
First location should be the primary service location. Only four total locations are available per individual NPI.

Primary service location:	**Billing NPI:**

Street address line 1:

Street address line 2:

City:	State:	ZIP:

County:

Phone:	Fax:

Office hours:

Monday:	Friday:
Tuesday:	Saturday:
Wednesday:	Sunday:
Thursday:	

Secondary service location:	**Billing NPI:**

Street address line 1:

Street address line 2:

City:	State:	ZIP:

County:

Phone:	Fax:

Office hours:	
Monday:	Friday:
Tuesday:	Saturday:
Wednesday:	Sunday:
Thursday:	

Other service location:	**Billing NPI:**

Street address line 1:

Street address line 2:

City:	State:	ZIP:

County:

Phone:	Fax:

Office hours:	
Monday:	Friday:
Tuesday:	Saturday:
Wednesday:	Sunday:
Thursday:	

Other service location:	**Billing NPI:**

Street address line 1:

Street address line 2:

City:	State:	ZIP:

County:

Phone:	Fax:

Office hours:	
Monday:	Friday:
Tuesday:	Saturday:
Wednesday:	Sunday:
Thursday:	