



PROVIDER APPLICATION/CHANGE FORM

INSTRUCTIONS: Type or print your information on this application. If a question does not apply to your application, write "N/A" in the field. Read instructions for information detail. Include copies of supporting documentation.

CHECK THE APPROPRIATE BOX:

- New Applicant**
 Change of Information
 Credential Request

SECTION I – ORGANIZATION INFORMATION

Instructions:

- **Organization Name/Provider Applicant** Enter legal name (e.g., Inc., LLC), if your agency uses a "doing business as" (DBA), then also enter your DBA name.
- **Address** Indicate address where services are primarily provided. General information and correspondence will be sent to this address.
- **Federal TIN** Taxpayer Identification Number (TIN) This is the number used to report income to the IRS (enter EIN or SSN if applicable).
- **NPI Number** National Provider Identifier Number. Required for all Health Care providers. **Medicaid Number, Medicare Number**
- **Handicap Accessible** List type of accessibility available to members
- **Name of Contact Person** List the name of the person within your organization who can be listed as a main contact.
- **Remit/Billing Address** Enter if billing address is different.

Organization Legal Name (Provider Applicant)		Federal TIN or SSN	Organization NPI Number
Organization Address: (Street)		Organization WI Medicaid Number	Organization Medicare Number
Organization Address: (City)		(State)	(Zip Code)
		Handicap Accessible <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Wheelchair <input type="checkbox"/> Braille <input type="checkbox"/> Other _____	
Organization Phone Number		Organization Fax Number	ROI Fax Number
Name of Contact Person	Title/Position	Contact Person Phone Number	Contact Person E-mail Address
Name of Authorized Contract Signor	Title/Position	Contract Signor Phone Number	Contract Signor E-mail Address
Available Services:	Counties Served: (List all counties served)	Populations Served: (Check all that apply)	
	<input type="checkbox"/> Chippewa <input type="checkbox"/> Dunn <input type="checkbox"/> Eau Claire <input type="checkbox"/> Pierce <input type="checkbox"/> St. Croix <input type="checkbox"/> Other:	<input type="checkbox"/> Frail Elders <input type="checkbox"/> Physical Disabilities <input type="checkbox"/> Developmental Disabilities	



SECTION II – PROVIDER INFORMATION

Instructions: Respond to all applicable items, write "N/A" if not applicable. A separate form will be needed for each Provider.

- **Provider Name** Enter only one name.
- **Specialty** Type of service provided (such as dental, emergency transportation, home health, personal care, pharmacy, physician, psychiatric counseling, respiratory care services, etc.).
- **Medicare and Medicaid Numbers** Required for certified providers. Attach a copy of current certification/license.
- **DEA Number** Drug Enforcement Administration. All Providers certified to prescribe drugs.
- **CLIA Number** Provider who will bill for laboratory tests. Attach a copy of current Clinical Laboratory Improvement Amendment (CLIA) certificate.
- **UPIN Number** Unique Physician Identification Number. Physicians must answer.
- **NPI Number** National Provider Identifier number.

Provider Name (Last, First, Middle Initial)		Professional Credentials <input type="checkbox"/> <input type="checkbox"/> DO <input type="checkbox"/> DDS <input type="checkbox"/> Other (specify) _____	
Title	Specialty	Other Languages Spoken (Other than English)	
WI State License Number	Medicare Provider Number	Medicare Provider Number	
CLIA Number	Hospital		
UPIN Number	NPI Number		

N/A

SECTION III – SERVICE LOCATION INFORMATION

Instructions: Service locations of the above Provider. Respond to all applicable items, write "N/A" if not applicable.

Primary Service Location Name		Hours of Operation	
Address: (Street, City, State, Zip Code)		County	Specialty
Telephone Number	Fax Number	Medical Records Information Fax Number	
Additional Service Location Name		Hours of Operation	
Address: (Street, City, State, Zip Code)		County	Specialty
Telephone Number	Fax Number	Medical Records Information Fax Number	
Additional Service Location Name		Hours of Operation	
Address: (Street, City, State, Zip Code)		County	Specialty
Telephone Number	Fax Number	Medical Records Information Fax Number	



SECTION IV - IMPORTANT NOTICES

In receiving this application from the individual or other entity named as "Provider Applicant", Community Health Partnership, Inc. relies on the truth of all the following statements:

- All information entered is accurate and complete, and that if any of that information changes Provider will timely notify Community Health Partnership, Inc. of any such change.
- By submitting this form, Provider agrees to abide by all statutes, rules, and policies governing Wisconsin Medicaid.
- Provider knows and understands the certification requirements for the applicable provider types.

NOTIFICATION OF CHANGES

You must inform Community Health Partnership, Inc. of any Provider additions and/or changes in licensure, certification, group affiliation, corporate name, ownership, and physical or payee address.

Failure to notify Community Health Partnership, Inc. and Wisconsin Medicaid of these types of changes may result in:

- Incorrect reimbursement
- Misdirected payment
- Claim denial

Authorized Signature of Provider Applicant	Date
--	------

Return completed form along with supporting documentation to:

Community Health Partnership, Inc.
 Attn: Provider Relations Department
 2240 East Ridge Center
 Eau Claire, WI 54701
 Phone: 715-838-2900
 Fax: 715-838-2910
 Website: www.communityhealthpartnership.com

FOR OFFICE USE ONLY		
Date Received _____	Effective Date _____	System Set Up Complete _____