

**APPENDIX 3 – PROVIDER CREDENTIAL INFORMATION FORM**

**PRACTITIONER CREDENTIAL DATA FORM**

**INSTRUCTIONS:** Type or print your information on this form. If a question does not apply, write "N/A" in the field. A separate form will be needed for each Provider.

**CHECK THE APPROPRIATE BOX:**

- New Practitioner
  Change of Information
  CHP Credential Request

<b>Effective/Practice Start Date:</b>		
<b>Practitioner Name:</b>		
<b>Professional Degree:</b>		
<b>Gender:</b>		
<b>Social Security Number:</b>		
<b>Date of Birth:</b>		
<b>Languages Spoken:</b>		
<b>Primary Care/Specialist:</b>		
<b>Accepting New Patients:</b>		
<b>Specialty:</b>		
<b>Board Certified:</b>		Date Certified: Expiration Date:
<b>2nd Board Certified:</b>		Date Certified: Expiration Date:
<b>Medical School:</b>		Graduation Date:
<b>Group Name:</b>		
<b>Federal Tax ID:</b>		
<b>Primary Location:</b>		Phone: Fax: ROI Fax :
<b>Secondary Location:</b>		Phone: Fax: ROI Fax:
<b>Billing Address:</b>		Phone: Fax:
<b>Accepting Medicare Assignment:</b>		
<b>Medicare Number:</b>		
<b>Medicaid Number:</b>		

<b>UPIN:</b>		
<b>NPI:</b>		
<b>WI State License:</b>		Date Issued: Expiration Date:
<b>DEA:</b>		Expiration Date:
<b>NPDB:</b>		Adverse Action:
<b>Hospital Affiliations:</b>		

**IMPORTANT NOTICES**

In receiving this form from the individual or other entity named as "Practitioner" 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 Practitioner 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 Practitioner	Date
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Return completed form to:

Community Health Partnership, Inc.  
 Attn: Jill Sadorf, Health Plan Operations Coordinator  
 2240 East Ridge Center  
 Eau Claire, WI 54701  
 Phone: 715-858-7820  
 Fax: 715-838-2910  
 Website: www.communityhealthpartnership.com

FOR OFFICE USE ONLY		
Date Received _____	Effective Date _____	Peer Review Approved _____