group health Cooperative of eau claire

Network Participant

Application Form

Legal Name (including d.b.a.) _____

Main Physical Location (street, city, state, zip+4 - list additional locations on page 2) _____

_____

Main Mailing Address (if different) _____

_____

Main Phone: _____ Fax: _____ Website: _____

Billing/Remit Address (if different - street, city, state, zip+4) _____

_____ Billing Phone: _____

Organizational NPI#s: _____ Federal Tax ID# _____ WI Medicaid Certified? ☐ Yes ☐ No

County(s) Served: _____ Requested Start Date: _____

Type of Facility(s): ☐ Clinic ☐ SNF ☐ Home Health ☐ Hospital ☐ Other: _____

Number of locations (list on page 2): _____ Number of licensed practitioners (list on page 3): _____

Reason for interest in becoming a Group Health Cooperative network participant: _____

_____

List All Accreditations & Certifications (Rural Health Clinic, Federally Qualified, HPSA, JCAHO, AAAHC, CARF, CCAC, CHAPS, etc.):

_____

Behavioral Health Clinics: Is the clinic location certified under DHS Chapter 35 and/or DHS Chapter 75? ☐ Yes ☐ No
If yes, please provide the certification numbers of this main location (list additional locations on page 2): _____

Are there certified branch locations associated with this clinic? ☐ Yes ☐ No
If yes, please provide the certification numbers of these locations along with their respective listings on page 2.

Complete separate form for each unique IRS Federal Tax Identification Number

Return completed form and W9 to: Group Health Cooperative of Eau Claire
Attn: Contracting & Provider Relations
PO Box 3217
Eau Claire, WI 54702-3217

Fax: 715.552.3500
Email: provider.relations@group-health.com

Questions? Feel free to give us a call at **(715) 852-5706** and we will help you through the process.

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CONTACT INFORMATION

Authorized Contract Signor: _____ _____ _____
First/Last Name | Title/Position | Email address

Contracting Contact (if different): _____ _____ _____
First/Last Name | Title/Position | Email address

Billing Contact: _____ _____ _____
First/Last Name | Title/Position | Email address

Office Manager (if different): _____ _____ _____
First/Last Name | Title/Position | Email address

Credentialing Contact: _____ _____ _____
First/Last Name | Title/Position | Email address

MULTIPLE LOCATION INFORMATION

Location 1

_____ _____
Location Name | DHS Ch. 35/75 Cert. Numbers (if applicable)

_____ _____
Address | City, State, Zip

_____ _____ _____
NPI | Phone | Fax

Location 2

_____ _____
Location Name | DHS Ch. 35/75 Cert. Numbers (if applicable)

_____ _____
Address | City, State, Zip

_____ _____ _____
NPI | Phone | Fax

Location 3

_____ _____
Location Name | DHS Ch. 35/75 Cert. Numbers (if applicable)

_____ _____
Address | City, State, Zip

_____ _____ _____
NPI | Phone | Fax

Location 4

_____ _____
Location Name | DHS Ch. 35/75 Cert. Numbers (if applicable)

_____ _____
Address | City, State, Zip

_____ _____ _____
NPI | Phone | Fax

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PHYSICIAN/PRACTITIONER INFORMATION	Practice Locations	Medicaid Certified
Name & Credentials ______ Individual NPI# ______ Specialty/Title ______	☐ Location 1 ☐ Location 2 ☐ Location 3 ☐ Location 4	☐ Yes ☐ No
Name & Credentials ______ Individual NPI# ______ Specialty/Title ______	☐ Location 1 ☐ Location 2 ☐ Location 3 ☐ Location 4	☐ Yes ☐ No
Name & Credentials ______ Individual NPI# ______ Specialty/Title ______	☐ Location 1 ☐ Location 2 ☐ Location 3 ☐ Location 4	☐ Yes ☐ No
Name & Credentials ______ Individual NPI# ______ Specialty/Title ______	☐ Location 1 ☐ Location 2 ☐ Location 3 ☐ Location 4	☐ Yes ☐ No
Name & Credentials ______ Individual NPI# ______ Specialty/Title ______	☐ Location 1 ☐ Location 2 ☐ Location 3 ☐ Location 4	☐ Yes ☐ No
Name & Credentials ______ Individual NPI# ______ Specialty/Title ______	☐ Location 1 ☐ Location 2 ☐ Location 3 ☐ Location 4	☐ Yes ☐ No
Name & Credentials ______ Individual NPI# ______ Specialty/Title ______	☐ Location 1 ☐ Location 2 ☐ Location 3 ☐ Location 4	☐ Yes ☐ No
Name & Credentials ______ Individual NPI# ______ Specialty/Title ______	☐ Location 1 ☐ Location 2 ☐ Location 3 ☐ Location 4	☐ Yes ☐ No

Make additional copies of this page if necessary – or – Attach/enclose your own documents.

Credentialing of individual practitioners may begin following acceptance of your Network Participant Application Form.

group-health.com | 2503 N. Hillcrest Pkwy. Altoona WI 54720 | p. 715.552.4300 or 888.203.7770 | f. 715.552.3500

I verify that all of the above information is current, correct and complete as of the date of my signature below. As an administrative representative of this organization, I have the authority to sign on behalf of the organization.

I agree to inform Group Health Cooperative of Eau Claire of any of the above changes prior to their occurrence. Failure to notify Group Health Cooperative of Eau Claire and Wisconsin Medicaid of these types of changes may result in:

- **Incorrect reimbursement**
- **Misdirected payment**
- **Claim denial**

PLEASE NOTE: this Network Participant Application Form is to obtain preliminary Applicant information for contracting and credentialing purposes; it does not constitute a contract for services. Applicant will be considered in-network only after completion of any necessary credentialing and full execution of Service Agreement. By submitting this Application, Applicant is indicating willingness to provide any/all services for which it is qualified/licensed to members of all health plans administered by Group Health Cooperative of Eau Claire.

_____ _____

Authorized Signature & Title **Date**