Network Participant
Application Form

Personal Information				
Legal Name			D/B/A	
Main Physical Location (street, city, state, zip+4 - list additional locations on page 2)				
Main Mailing Address (if different)				
Main Phone Number	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 Health Center ☐ JCAHO ☐ AAAHC ☐ CARF ☐ CHAPS ☐ DNV ☐ Other_______				
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, W9 and any accreditation certificates to:

Group Health Cooperative of Eau Claire
Attn: Contracting & Provider Relations
PO Box 3217
Eau Claire, WI 54702-3217

Fax: 715.598.7534
Email: providerrelations@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	

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

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

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

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.

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GHC22027

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 and Title Date

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