

# ADD A PROVIDER

## to an Existing Contract



Please complete this entire form to add a provider to an existing contract, such as when a new provider joins the clinic or group. If a question is not applicable, answer with NA.

First Name		Last Name		Middle Initial
Practitioner Type		Primary Care	Specialist	Degree
Practitioner CAQH Number				
Practitioner Specialty for Location				
Practitioner Taxonomy				
Clinic/Group Name				
Practitioner Primary Office Address				
City, State, Zip Code				
Office Phone			Office Fax	
Office Hours				
Billing Address (if different than above)				
Billing Phone			Billing Fax	
Tax Identification #				
Group NPI #				
Practitioner NPI #				
Practitioner Medicaid #				
Practitioner Medicare #				
Credentialing Contact Name				
Credentialing Fax Number				
WI Medical License #				Expiration Date
DEA #			Expiration Date	
Gender				
Ethnicity				
Languages Spoken				
Group Start Date				
Print in Provider Directory		Yes	No	

**Return completed form:**

Email: [mhs-wipdm@mhswi.com](mailto:mhs-wipdm@mhswi.com)  
 Mail: MHS Health Wisconsin  
 Attn: Provider Data Management  
 115 S. 84th Street, Suite 350  
 Milwaukee, WI 53214  
 Confidential fax: 1-866-671-3669

**Contact Name (Print)**

**Signature**

**Contact Email**

**Date**

To start a new contract, please use the appropriate form at [mhswi.com/providers/become-a-provider.html](http://mhswi.com/providers/become-a-provider.html)