mhs health wisconsin

Credentialing Application

Facility, Ancillary, and Clinic/Center

APPLICATION TYPE

☐ Initial Credentialing ☐ Recredentialing ☐ Add a new site/service to a current contract

FACILITY DETAILS

Legal Name ______________________________

Parent Company/Health System (if applicable) ______________________________

Doing Business As (DBA) ______________________________

Federal Tax ID ______________ **NPI** ______________ **Taxonomy** ______________

FACILITY TYPE

☐ Hospital
☐ Community Mental Health Center
☐ Rehabilitation Center
☐ Rehabilitative Behavioral Health Services (RBHS)
☐ Assisted Long-Term Care Facility
☐ Outpatient Clinic
☐ Substance Use Treatment Facility
☐ Adult Living Facility
☐ Home Health
☐ Agency FQHC / RHC
☐ Intensive Family Intervention
☐ Other (specify):

FACILITY PRACTICE LOCATIONS

Do you have more than one location?

☐ If YES, *please refer to Addendum on Page 6 to fill out information for each additional location.*

☐ If NO, *this form concludes on Page 5.*

Location #1

Location Name ______________________________

Address ______________________________

Phone ______________________ Fax ______________________

Psychiatric / Mental Health Services *(Mark all services and ages that apply.)*

	Child	Adolescent	Adult	Geriatric
☐ Inpatient	☐	☐	☐	☐
☐ Partial (PHP)	☐	☐	☐	☐
☐ IOP	☐	☐	☐	☐
☐ Residential	☐	☐	☐	☐
☐ Observation	☐	☐	☐	☐
☐ Other	☐	☐	☐	☐
☐ Other	☐	☐	☐	☐

Substance Use Disorder / Chemical Dependency Services *(Mark all services and ages that apply.)*

	Child	Adolescent	Adult	Geriatric
☐ Inpatient	☐	☐	☐	☐
☐ Partial (PHP)	☐	☐	☐	☐
☐ IOP	☐	☐	☐	☐
☐ Residential	☐	☐	☐	☐
☐ Observation	☐	☐	☐	☐
☐ Other	☐	☐	☐	☐
☐ Other	☐	☐	☐	☐

☐ Methadone services offered ☐ Suboxone services offered

ECT Offered ☐ Inpatient ☐ Outpatient

Genders treated ☐ Male ☐ Female

I/P Beds (Mental Health) ________________ # I/P Beds (Substance Use) ________________

Accessibility and Hours for this Location

Languages Spoken *(Check all that apply)*

☐ English	☐ Spanish	☐ Hmong	☐ Burmese	☐ Rohingya
☐ Somali	☐ Russian	☐ Ukrainian	☐ Arabic	☐ Pashto
☐ Hindi	☐ German	☐ Polish	☐ Italian	☐ French
☐ Swahili	☐ Yiddish	☐ Vietnamese	☐ Korean	☐ Laotian
☐ Chinese Mandarin	☐ Other ________________			

☐ Open at least 5 days per week

☐ Wheelchair accessible

Daily Hours *(Check all the days that apply and add daily hours of operation.)*

☐ Monday	________	☐ am ☐ pm	*to*	________	☐ am ☐ pm
☐ Tuesday	________	☐ am ☐ pm	*to*	________	☐ am ☐ pm
☐ Wednesday	________	☐ am ☐ pm	*to*	________	☐ am ☐ pm
☐ Thursday	________	☐ am ☐ pm	*to*		☐ am ☐ pm
☐ Friday	________	☐ am ☐ pm	*to*	________	☐ am ☐ pm
☐ Saturday	________	☐ am ☐ pm	*to*	________	☐ am ☐ pm
☐ Sunday	________	☐ am ☐ pm	*to*	________	☐ am ☐ pm

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ADMINISTRATIVE AND BILLING INFORMATION

Administrative Mailing Address ____________________

City ____________________ State ____________ Zip ____________

Administrative Phone ____________________ Email ____________________

Billing Address ____________________

City ____________________ State ____________ Zip ____________

Medicare Provider # ____________________ Medicaid Provider # ____________________

☐ All HIPAA transactions are conducted from a centralized location

Contact Information

	Name	Phone	Email
Managed Care Contact			
Credentialing Contact			
Billing Contact			
Clinical Director			

ACCREDITATION INFORMATION *(Mark and fill out all that apply.)*

Agency Name	Acronym	Issue Date	Expiration Date
☐ Accreditation Commission for Healthcare	ACHC		
☐ American Association of Ambulatory Health Centers	AAAHC		
☐ American Osteopathic Hospital Association	AOHA		
☐ Commission on Accreditation for Rehab Facilities	CARF		
☐ Community Health Accreditation Program	CHAP		
☐ The Joint Commission	TJC		
☐ National Committee for Quality Assurance	NCQA		
☐ URAC	URAC		
☐ State Facility Operating License	N/A		
☐ Others (please list)	N/A		

LICENSURE / CERTIFICATION

#	Issuing Entity	Type of License/Certificate	License #	Expiration Date
#1				
#2				
#3				
#4				

INSURANCE COVERAGE

Current General Liability Insurance Carrier ______________________________

Note: Coverage must be at least $1 million each occurrence and $3 million aggregate.

Amount per Occurrence $ ____________________ Amount per Aggregate $ ____________________

Dates of Coverage From ____________________ to ____________________

SANCTIONS

1. Any malpractice claims, suits, settlements or proceedings involving the facility?

   ☐ Yes ☐ No

2. Any discipline, fines, exclusion, debarment, suspension, reprimand, sanction, censure, disqualification or restrictions regarding Medicare/Medicaid or other governmental plans?

   ☐ Yes ☐ No

3. Ever relinquished/withdrawn or failed to proceed with an application to avoid adverse action or while under investigation?

   ☐ Yes ☐ No

4. Any sanctions by a PSRO/PRO, third-party payer, or regulatory agency (CLIA, OSHA, etc.)?

   ☐ Yes ☐ No

5. Has the facility's DEA or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked?

   ☐ Yes ☐ No

6. Has any employee with direct care access to members ever been convicted, pled guilty, or pled no contest to any felony including violence, child abuse or sexual offense?

   ☐ Yes ☐ No

7. Has the corporation, an officer or a board member ever been convicted of a felony?

   ☐ Yes ☐ No

FACILITY RESPONSIBILITY

As a prospective/current provider, the Facility is responsible for ensuring that any licensed practitioners under its employment or association are fully qualified and legally licensed to perform assigned functions. The Facility agrees to notify the Plan in a timely manner about practitioner changes and cooperate in the submission of completed applications as required to satisfy credentialing/recredentialing requirements. Information submitted in this application will be held confidential by the Plan and provided only to individuals on a need-to-know basis. The Facility agrees to participate in credentialing review functions and authorizes contact with prior/current associates and verification entities as required by accrediting bodies or regulatory agencies. The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility is selected or retained, after such selection or retention, the Facility agrees to inform MHS Health Wisconsin in writing within 10 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by MHS Health Wisconsin on its own behalf and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any MHS Health Wisconsin programs or any program until such time as this Facility receives notice of participation.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photocopy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. A photocopy shall have the same force and effect as the signed original.

Signature of Facility CEO (or authorized designee) ______________________________

Name ______________________________

Title ______________________________

Date ______________________________

If you have only one location, you may stop here.

Please fill out ***Addendum Additional Locations*** if you have two or more locations.

Send your completed application and any additional location addendum documents to
Email: mhs-wipdm@mhswi.com
Mail: MHS Health Wisconsin, Attn: Provider Data Management, 115 S. 84th Street, Suite 350, Milwaukee, WI 53214