

**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**

- |   |   |
|---|---|
| <input type="checkbox"/> Hospital   | <input type="checkbox"/> Substance Use Treatment Facility |
| <input type="checkbox"/> Community Mental Health Center                   | <input type="checkbox"/> Adult Living Facility            |
| <input type="checkbox"/> Rehabilitation Center                            | <input type="checkbox"/> Home Health                      |
| <input type="checkbox"/> Rehabilitative Behavioral Health Services (RBHS) | <input type="checkbox"/> Agency FQHC / RHC                |
| <input type="checkbox"/> Assisted Long-Term Care Facility                 | <input type="checkbox"/> Intensive Family Intervention    |
| <input type="checkbox"/> Outpatient Clinic                                | <input type="checkbox"/> 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
<input type="checkbox"/> Inpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Partial (PHP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IOP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Residential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Observation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Child	Adolescent	Adult	Geriatric
<input type="checkbox"/> Inpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Partial (PHP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IOP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Residential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Observation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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     English     Spanish     Hmong     Burmese     Rohingya  
*(Check all that apply)*     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

**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
<input type="checkbox"/> Accreditation Commission for Healthcare	ACHC	_____	_____
<input type="checkbox"/> American Association of Ambulatory Health Centers	AAHC	_____	_____
<input type="checkbox"/> American Osteopathic Hospital Association	AOHA	_____	_____
<input type="checkbox"/> Commission on Accreditation for Rehab Facilities	CARF	_____	_____
<input type="checkbox"/> Community Health Accreditation Program	CHAP	_____	_____
<input type="checkbox"/> The Joint Commission	TJC	_____	_____
<input type="checkbox"/> National Committee for Quality Assurance	NCQA	_____	_____
<input type="checkbox"/> URAC	URAC	_____	_____
<input type="checkbox"/> State Facility Operating License	N/A	_____	_____
<input type="checkbox"/> 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**

- Any malpractice claims, suits, settlements or proceedings involving the facility?  
 Yes     No
- Any discipline, fines, exclusion, debarment, suspension, reprimand, sanction, censure, disqualification or restrictions regarding Medicare/Medicaid or other governmental plans?  
 Yes     No
- Ever relinquished/withdrawn or failed to proceed with an application to avoid adverse action or while under investigation?  
 Yes     No
- Any sanctions by a PSRO/PRO, third-party payer, or regulatory agency (CLIA, OSHA, etc.)?  
 Yes     No
- Has the facility's DEA or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked?  
 Yes     No
- 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
- 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 more locations.