



10700 Research Drive  
Suite 300  
Milwaukee, WI 53226

### New Provider Request Form

Please complete the entire form when a new Physician joins the clinic or group.

Last Name, First Name, Middle Initial, Degree	
Providers CAQH Number	
Clinic Name	
Practicing Specialty for this Location	
Primary Office Address	
City, State, Zip Code	
Office Phone and Fax Number	
Office Hours	
Billing Address (if different than above)	
Billing Phone and Fax Number	
Tax Identification #	
Medicaid #	
Medicare #	
NPI #	
Medical Records Contact Name	
Medical Records Fax Number	
UPIN	
Taxonomy	
WI Medical License #	
DEA #	
Gender	
Languages Spoken	

Signature: \_\_\_\_\_ Contact Name (Print): \_\_\_\_\_

Email Address: \_\_\_\_\_ Date: \_\_\_\_\_

**Mail completed forms to:**

Attn: Credentialing Department  
MHS Health Wisconsin  
10700 W Research Dr  
Suite 300  
Milwaukee, WI 53226

**Or confidential fax to:** 866-671-3669

1-888-713-6180  
TDD/TTY 1-800-947-3529

[mhswi.com](http://mhswi.com)