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 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	
Group Start Date	

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