



NEW PROVIDER ASSESSMENT REQUEST FORM

Instructions

This is not a credentialing application

Thank you for your interest in participating in our WPS Provider Network.

Completion of this application does not guarantee your network participation; however, should we extend an invitation to join our network, it will ensure that the correct agreement is sent for your review and signature. The following elements are required with the submission of your application. If these items are not included, your application will be considered incomplete:

- **W-9 Form.** We require this information to ensure that we have accurate IRS reporting information on file.
- **Your 25 most frequently billed codes with fees. Please include an encounter sheet or super bill.** We require this information from any newly contracted practitioner or clinic.
- **A copy of the face sheet from your malpractice insurance certificate.**
- **A copy of the face sheet from your general liability insurance certificate.**
- **Credentialing Application.**

Thank you again for your interest in participating in our WPS Provider Network. Please print, complete, and return your completed application form and required documentation to:

WPS Plan Development, Contracting

P. O. Box 8190, Madison, WI 53708

FAX (608) 226-4778

For further information, please feel free to call

(608) 226-4702

(608) 223-5875

Practice Information		Date:	
Legal Practice Name:		Federal Tax ID Number:	
Primary Business Address:		City:	State: Zip Code:
Telephone Number:		Fax Number:	
Counties Served:		Number of Locations:	
<input type="checkbox"/> Clinic <input type="checkbox"/> Facility <input type="checkbox"/> Home Health <input type="checkbox"/> Hospital <input type="checkbox"/> Other			
Specialty:		Number of licensed practitioners:	
Reason interested in becoming a WPS Preferred Provider:			
Contracting Contact Information			
<input type="checkbox"/> Dr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mr.			
First Name:	Last Name:	Business Title:	
Street Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Email Address:	
Credentialing Contact Information (if different from above)			
<input type="checkbox"/> Dr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mr.			
First Name:	Last Name:	Business Title:	
Street Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Email Address:	

This form is used by WPS for Assessment purposes and is not a credentialing application or a Preferred Provider Agreement. Within thirty (30) days of receipt of a completed request form, you should receive correspondence from WPS.

Section 1: General Information

1. Are you an employee or an affiliate of a large provider system (i.e. Aurora Health Care, Dean Health Systems, Inc., Mayo Health System, Ministry Health Care, Inc., etc.)?..... Yes No
If you answered “Yes” to the above question, please list all provider systems that apply:

2. Are you a member of, or do you intend to join, an Independent Physician Association (IPA), (i.e., Columbia St. Mary’s Physicians Network, Waukesha Elmbrook IPA, OakLeaf Medical Network, ThedaCare Premium Health Network, Aspirus Network Inc., Northstar Physicians Network, etc.)?.. Yes No
If you answered “Yes” to the above question, please list all the IPA memberships that apply:

3. Please list your hospital affiliations, if applicable.

4. Please list any outreach providers you work with, or refer to, if applicable. This includes, but is not limited to, anesthesia, pathology, laboratory, and/or radiology providers.

5. Are there practitioners at your clinic and/or facility who bill for their services under their own tax identification number (not the same tax identification number that you use)?..... Yes No
If you answered “Yes,” please list them below.

6. Are you leaving an existing practice and opening a new practice? Yes No

7. Does your organization have written policies and procedures for provider credentialing? Yes No

8. Is your practice credentialed or delegated with any nationally accredited organization?..... Yes No
If yes, please indicate what organization:

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Please remember to submit your 25 most commonly billed codes with fees. Also include an encounter sheet or super bill when submitting this application.

Section 2: Claim Submission

1. Do you currently submit claims electronically to WPS or use a clearinghouse?..... Yes No

If you answered “No” to the above question, are you interested in receiving information on how to submit claims electronically to WPS? Yes No

Contact Name: _____

Phone Number: _____

Section 3: Billing and Service Location Information

In addition to supplying the information below, we require that you submit a completed W-9 form with your Provider Application form.

Billing Name: _____

Billing Address: _____

City, State, ZIP: _____

Phone Number (include Area Code): _____ Fax Number: _____

E-mail Address: _____ Contact Name: _____

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First Location

Location Name or Provider Name: _____

National Provider Identification Number (NPI): _____

Address: _____

City, State, ZIP: _____

Phone Number: _____ Fax Number: _____

Phone Number for Appointments: _____ E-mail Address: _____

Second Location

Location Name or Provider Name: _____

National Provider Identification Number (NPI): _____

Address: _____

City, State, ZIP: _____

Phone Number: _____ Fax Number: _____

Phone Number for Appointments: _____ E-mail Address: _____

Third Location

Location Name or Provider Name: _____

National Provider Identification Number (NPI): _____

Address: _____

City, State, ZIP: _____

Phone Number: _____ Fax Number: _____

Phone Number for Appointments: _____ E-mail Address: _____

If more locations must be added, please photocopy this page as necessary or attach a listing of all your locations which includes the above information.

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Section 5: Credentialing Information

WPS has partnered with the Council for Affordable Quality Healthcare (CAQH) for credentialing. If you currently have a completed CAQH credentialing application, please update your information and release it to WPS by clicking on the link [“Wisconsin Physicians Service/Arise Health Plan.”](#) You also have the option to release your credentialing information globally. *Please note that your information will only be considered by WPS for participation in our PPO plans. It will not be considered for participation in the Arise networks.*

If you do not currently have a completed CAQH application, we encourage you to do so. We will be sending you an invitation if you have not already received one.

Your signed provider agreement will not be executed until credentialing is completed and approved by WPS. You will receive notification of your credentialing status. If credentialing is approved, WPS will proceed with finalizing your Preferred Provider Agreement.

If you have any questions in regard to our credentialing process, please contact Angie Dalton at 608-216-2533 or email at angela.dalton@wpsic.com

Facilities (i.e., hospital, ambulatory surgical center, skilled nursing facility, home health, durable medical equipment, etc.)

1. Do you employ any practitioners and bill for their services? Yes No

2. Do you currently hold accreditation/certification from any of the following agencies?
 - The National Committee for Quality Assurance (NCQA)
 - The Joint Commission on the Accreditation of Health Care Organizations (JCAHO)
 - Critical Access Certification
 - The American Accreditation Healthcare Commission (URAC)
 - The Accreditation Association for Ambulatory Health Care (AAAHC)
 - Medicare Certification
 - Continuing Care Accreditation Commission (CCAC)
 - Commission on Accreditation of Rehabilitation Facilities (CARF)
 - Other: _____

Please remember to include the following items with your completed application:

- W-9 Form**
- Your 25 most frequently billed codes with fees. Please include an encounter sheet or super bill.**
- A copy of the face sheet from your malpractice insurance certificate**
- A copy of the face sheet from your general liability insurance certificate**