



FORWARDHEALTH

PROVIDER SERVICES
313 BLETTNER BLVD
MADISON WI 53784

Scott Walker
Governor

Telephone: 800-947-9627
TTY: 711 or 800-947-3529

Kitty Rhoades
Secretary

State of Wisconsin
Department of Health Services

www.forwardhealth.wi.gov

<Month DD, YYYY>

<sequence number>

<Provider Name> <Title>

<Contact Name>

<Address 1>

<Address 2>

<City> <State> <Zip>-<Zip4>

Dear Wisconsin Chronic Disease Program Provider Applicant:

Thank you for requesting a Wisconsin Chronic Disease Program provider certification packet. Once you are a certified provider, you will play a significant part in improving the health of low-income people in your community.

Your application tracking number (ATN) for your certification is <ATN>. Please include your ATN on all correspondence relating to your certification application. Wisconsin Chronic Disease Program recommends you keep a copy of the completed materials for your records.

Please do the following to complete your certification packet:

1. Review and complete all required documents and applicable optional documents indicated below:

	Item	Required	Optional
1.	Provider Application, F-01540	X	
2.	Provider Agreement, F-1541	X	

2. Attach all completed documents listed in step 1 and any additional materials requested throughout this certification packet to this cover letter. It is important that you return this cover letter with your completed materials to ensure proper tracking of the application process.
3. Return the completed materials to ForwardHealth at Provider Enrollment, 313 Blettner Boulevard, Madison, WI 53784.

Please call Provider Services at (800) 947-9627 if you have questions regarding your certification packet.

Sincerely,

Wisconsin Chronic Disease Program
Provider Enrollment Department

Enclosures

F-01539 (07/12)

WISCONSIN CHRONIC DISEASE PROGRAM PROVIDER APPLICATION INFORMATION AND INSTRUCTIONS

The Wisconsin Chronic Disease Program (WCDP) requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Personally identifiable information about providers or other entities is used for purposes directly related to program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for services.

The use of this form is voluntary. However, in order to be certified, applicants are required to complete this form and submit it to the following address:

ForwardHealth
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

Applicants may call Provider Services at (800) 947-9627 with questions.

INSTRUCTIONS

Type or print the applicant's information on this application. Complete all sections. If a question does not apply to the applicant, he or she should write "N/A" in the field. Failure to complete all sections of this application will cause delay and may cause denial of certification.

Important Notice: In receiving this application from and granting WCDP certification to the individual or other entity, WCDP relies on the truth of all the following statements:

1. The individual or other entity submitted this application or authorized or otherwise caused it to be submitted.
2. All information entered on this application is accurate and complete, and that if any of that information changes after this application is submitted, the individual or other entity will timely notify WCDP of any such change.
3. The individual or other entity who completes this application on behalf of the applicant acknowledges on behalf of applicant that each and every piece of information provided on the application constitutes a statement or representation of a material fact that is made in an application for a WCDP benefit of payment, or that is made for use in determining rights to such benefit or payment, within the meaning of DHS 152-154, Wis. Admin. Code. By submitting this application or causing or authorizing it to be submitted, the individual or other entity agrees to abide by all statutes, rules, and policies governing WCDP within the meaning of ss. 49.68, 49.683 and 49.685, Wis. Stats., and the rules promulgated thereunder.
4. The individual or other entity knows and understands the certification requirements included in the application materials for the applicable provider types.

FOR OFFICE USE ONLY

ATN	Date Requested	Date Mailed
Provider ID	Effective Date	
Provider Type	Provider Specialty	



**WISCONSIN CHRONIC DISEASE PROGRAM
PROVIDER APPLICATION**

Instructions: Type or print clearly. Before completing this application, read Information and Instructions.

Type of Application

- Individual
- Organization / Group

This application is for one of the following:

- Initial Certification
- Reinstatement of Previous Provider ID
Previous Provider ID _____
- Change in Ownership
Previous Provider ID _____
Effective Date of Change in Ownership _____

SECTION I — IDENTIFYING INFORMATION AND ADDRESS INFORMATION

A. Identifying Information

Special Instructions

Name — Provider Applicant — Enter only one name. Organizations and groups using a “doing business as” (DBA) must enter the DBA name. The name entered on this line must match exactly the applicant’s name used on all other information supplied to WCDP.

Credentials — Enter the applicant’s credentials.

Date of Birth / Gender / Social Security Number — Required for individual applicants only. Enter the date in MM/DD/CCYY format.

Language — Indicate the language(s) spoken by individual applicants or organization/group applicant’s staff who are available to interpret for members. This information will be used in a provider directory that will be made available to the public.

Individuals — Applicant Only

Name — Provider Applicant (Last Name, First Name, Middle Initial)

Credentials

Date of Birth

Gender

- Male
- Female

Social Security Number

Organizations and Groups — Applicant Only

Name — Provider Applicant

Language

- English Spanish
- Russian Hmong
- Other _____

B. National Provider Identifier (NPI)

Special Instructions

NPI — Designate the NPI the provider will use for conducting business with WCDP. Applicants indicating blood bank certification in Section V of this application should leave this element blank.

NPI

SECTION I — IDENTIFYING INFORMATION AND ADDRESS INFORMATION (Continued)

C. Address Information

Special Instructions

Practice Location Information — Enter the complete address, (street, city, state, and ZIP+4 Code) where the provider applicant's office is physically located and where records are normally kept. **It is not acceptable to use a drop box or Post Office Box.** Individual applicants employed by a group or agency should indicate their employer's name in Address Line 1. Nurses in independent practice are required to indicate their home office address and should not indicate a WCDP member's residence or a billing service address.

WCDP Contact Person — Enter the name and telephone number and extension of the WCDP contact person. This information will be used for WCDP administrative purposes only.

Telephone Number for Member Use — Enter the telephone number for member use. This number will be made available to the public in a provider directory search.

Mailing Information — Enter the complete mailing name and address. The WCDP will send general information and correspondence to this address. (Official certification and audit correspondence will be sent certified. Failure to sign for official correspondence could result in decertification.)

Prior Authorization Information — Indicate the name and address to which prior authorization (PA) information should be sent. Enter the applicant's fax number and a contact person's telephone number.

Does the applicant work at a clinic or as part of a group? Yes No

If Yes, what is the clinic / organization's Provider ID? _____

Practice Location Information (Home Office Location for Nurses in Independent Practice)

Address Line 1		Address Line 2	
City	State	ZIP Code	ZIP+4 Extension
County		Name — WCDP Contact Person	
Telephone Number — WCDP Contact Person () Ext.		Telephone Number for Member Use ()	

Mailing Information

Name		Name — Contact Person	
Address Line 1		Address Line 2	
City	State	ZIP Code	ZIP+4 Extension

Prior Authorization Information (If not completed, PA information will be mailed to the practice location.)

Name		Name — Attention Line	
Address Line 1		Address Line 2	
City	State	ZIP Code	ZIP+4 Extension
Fax Number — Provider		Telephone Number — Contact Person	

Continued

SECTION II — MEDICARE ENROLLMENT INFORMATION

Special Instructions

Medicare Part A and Part B — Enrollment information is required for Medicare-certified providers.

Is the provider Medicare Part A enrolled? Yes No Effective Date _____

Is the provider Medicare Part B enrolled? Yes No Effective Date _____

SECTION III — ADDITIONAL INFORMATION

Special Instructions

Respond to all applicable items:

- Applicants who are licensed are required to complete Element 1.
- Provider group applicants are required to complete Element 2.

1. Individual or Organization License and State of License

2. Does the applicant have two or more WCDP-certified providers working at the clinic? Yes No
If yes, list the NPIs in the spaces provided.

Provider NPI	Provider NPI	Provider NPI

SECTION IV — PROVIDER FINANCIAL INFORMATION

Special Instructions

Taxpayer Identification Number (TIN) — Enter the TIN that should be used to report income to the Internal Revenue Service (IRS). The number entered must be the TIN of the taxpayer name entered. The taxpayer's name and TIN must match exactly what is on record with the IRS.

Name — Taxpayer — Enter the taxpayer's name for the TIN exactly as it is recorded with the IRS. The WCDP will generate payments using the taxpayer's name. Individuals reporting income to the IRS under an SSN must enter the individual name recorded with the IRS for the SSN.

TIN Type — Check whether the TIN is an EIN or SSN.

TIN Effective Date — Enter the date the TIN became effective for the applicant.

TIN End Date — Enter the date the TIN ends.

Checks and Remittance Advice Address — Enter the complete address to which check and remittance advices should be mailed.

Name — Financial Contact Person — Enter the name of the financial contact person.

Telephone Number — Contact Person — Enter the telephone number of the contact person.

1099 Mailing Address — Enter the complete address to which the IRS Form 1099 should be sent.

Taxpayer Information

Taxpayer Identification Number (TIN)		Name — Taxpayer	
TIN Type	TIN Effective Date	TIN End Date	
<input type="checkbox"/> EIN <input type="checkbox"/> SSN			

Continued

SECTION IV — PROVIDER FINANCIAL INFORMATION (Continued)

Checks and Remittance Advice Information

Address Line 1		Address Line 2	
City	State	ZIP Code	ZIP+4 Extension
Name — Financial Contact Person		Telephone Number — Contact Person	

1099 Mailing Address

Address Line 1		Address Line 2	
City	State	ZIP Code	ZIP+4 Extension

SECTION V — TYPE OF CERTIFICATION

Check the provider type for this application from the list below. A separate application is required for each provider type for which the applicant wishes to be certified. An individual may choose only one provider type per application.

<ul style="list-style-type: none"> <input type="checkbox"/> Ambulance <ul style="list-style-type: none"> <input type="checkbox"/> Air Ambulance <input type="checkbox"/> Water Ambulance <input type="checkbox"/> Land Ambulance <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Anesthesiology Assistant* <input type="checkbox"/> Certified Registered Nurse Anesthetist <input type="checkbox"/> End-Stage Renal Disease <ul style="list-style-type: none"> <input type="checkbox"/> Free Standing <input type="checkbox"/> Hospital Affiliated <input type="checkbox"/> Federally Qualified Health Center <input type="checkbox"/> Hospital <input type="checkbox"/> Independent Lab <ul style="list-style-type: none"> <input type="checkbox"/> Blood Banks <input type="checkbox"/> Medical Supply <ul style="list-style-type: none"> <input type="checkbox"/> Orthotist <input type="checkbox"/> Prosthetist <input type="checkbox"/> Orthotist / Prosthetist <input type="checkbox"/> Medical Vendor / Durable Medical Equipment (DME) 	<ul style="list-style-type: none"> <input type="checkbox"/> M.R. Facility <input type="checkbox"/> Nurse Practitioner <ul style="list-style-type: none"> <input type="checkbox"/> Certified Pediatric Nurse Practitioner <input type="checkbox"/> Certified Family Nurse Practitioner <input type="checkbox"/> Other Nurse Practitioner <input type="checkbox"/> Nurse Services <ul style="list-style-type: none"> <input type="checkbox"/> Private Duty / Respiratory Care <input type="checkbox"/> Private Duty <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Licensed Practical Nurse <input type="checkbox"/> Pharmacy <input type="checkbox"/> Physician (See Below) <input type="checkbox"/> Physician Assistant* <input type="checkbox"/> Physician Group / Clinic (See Below) <input type="checkbox"/> Portable X-ray <input type="checkbox"/> Other _____
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* Individuals must be supervised and cannot independently bill the WCDP. The clinic must submit claims.

Physicians, or a group/clinic of a physician, must indicate the specialty below. (Select one specialty.)

<ul style="list-style-type: none"> <input type="checkbox"/> Anesthesiology <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Clinic (Multi-specialty) <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Family Practice <input type="checkbox"/> Gastroenterology <input type="checkbox"/> General Practice <input type="checkbox"/> General Surgery <input type="checkbox"/> Geriatrics <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurological Surgery <input type="checkbox"/> Neurology <input type="checkbox"/> Nuclear Medicine 	<ul style="list-style-type: none"> <input type="checkbox"/> Oncology and Hematology <input type="checkbox"/> Orthopedic Surgery <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pathology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Physical Medicine and Rehab <input type="checkbox"/> Preventative Medicine <input type="checkbox"/> Proctology <input type="checkbox"/> Pulmonary Disease <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Radiology <input type="checkbox"/> Thoracic and Cardiovascular Surgery <input type="checkbox"/> Urgent Care <input type="checkbox"/> Urology
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SECTION VI — APPLICANT'S TYPES OF BUSINESS

Applicant's Type of Practice (Check appropriate box.)

- Individual.
- Sole Proprietor:
County and State Where Registered _____
- Corporation for Nonprofit
- Limited Liability
- Corporation for Profit
State of Registration _____

Names of Corporate Officers _____

- Partnership.
State of Registration _____

Names of All Partners and SSNs (Use additional sheet if needed.)
Name _____ SSN _____
Name _____ SSN _____
- Government (Check one.)
 - County Agency
 - State Agency
 - Municipality (City, Town, Village)
 - Tribal Agency
 - City / County Agency

SECTION VII — TAXONOMY

Special Instructions

Copy this page and complete as needed.

A primary taxonomy code must be on file with WCDP at all times. Additional taxonomy codes are optional.

Primary Taxonomy Code	Additional Taxonomy Code
Additional Taxonomy Code	Additional Taxonomy Code
Additional Taxonomy Code	Additional Taxonomy Code

SECTION VIII — NPI SUBPARTS (Hospital Providers Only)

Special Instructions

Copy this page and complete as needed.

Hospital providers **only** may add NPI subparts in this section. An associated taxonomy code is required for each NPI subpart listed.

NPI Subpart	Associated Taxonomy Code
NPI Subpart	Associated Taxonomy Code
NPI Subpart	Associated Taxonomy Code

**WISCONSIN CHRONIC DISEASE PROGRAM
PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF
TERMS OF PARTICIPATION**
(Standard for Individual and Clinic / Group / Agency Providers)

By signature of its authorized representative below,

(Provider's Name and Number [if assigned] Name **must** exactly match the name used on **all** other documents)

hereinafter referred to as the "Provider," a certified provider of health care services under the Wisconsin Chronic Disease Program (WCDP), hereby agrees and acknowledges as follows:

1. The Provider acknowledges that the restrictions and conditions listed below and in §§ 49.68, 49.683, and 49.685, Wis. Stats., as applicable, and the rules promulgated thereunder govern its participation as a provider in WCDP:
 - a. The Provider is subject to certain requirements and restrictions under state and federal laws in addition to those referred to in Section 1 above, as well as applicable WCDP provider publications including, but not limited to, the ForwardHealth Online Handbook.
 - b. The Department of Health Services (DHS) offers, or will offer in the future, the Provider several options for submitting claims and other information to the DHS, including electronic and Web-based submission methodologies that require the input of secure and discrete access codes but not written provider signatures. The Provider has sole responsibility for maintaining the privacy and security of any access code the Provider uses to submit information to the DHS, and any individual who submits information using such access code does so on behalf of the Provider, regardless whether the Provider gave the access code to the individual or had knowledge that the individual knew the access code or used it to submit information to the DHS. The Provider is responsible for repayment to the DHS of any overpayment based on any information submitted by any third party in the Provider's name or provider number or using the Provider's access code, with or without the Provider's knowledge or consent, regardless of the manner in which the information was submitted.
 - c. The Provider is subject to certain federal and state laws regarding confidentiality and disclosure of medical records or other health information, including the Administrative Simplification provisions of the Health Insurance Portability Act of 1996 (HIPAA) for all services, information, and transactions, including electronic transactions, privacy, and security regulations.
 - d. The omission of any applicable restriction or condition from this section does not excuse the Provider from complying with that restriction or condition. The Provider further acknowledges that by submitting claims as a WCDP provider, the Provider becomes subject to the foregoing and all other applicable WCDP restrictions and conditions. The Provider further acknowledges that the DHS has informed the Provider how to obtain access to materials describing all restrictions and conditions applicable to the Provider's participation in the WCDP, both in paper version and via the Internet, e-mail, or other electronic methods. The Provider further acknowledges that all applicable restrictions and conditions govern the Provider's participation in the WCDP, regardless of whether or not the Provider has actual knowledge of those restrictions and conditions.



2. The Provider will comply with all applicable provisions of HFS 152, 153, and 154, Wis. Admin. Code, and that if the Provider fails to comply with any such provision, the DHS may terminate the Provider's participation in the WCDP. This Agreement and Acknowledgement remains in effect as long as the Provider is certified to participate in the WCDP.

3. The Provider acknowledges that any statement made in this document or in the Wisconsin Chronic Disease Program Provider Application, F-1540, process constitutes a statement or representation of a material fact knowingly and willfully made or caused to be made by the Provider in an application for a benefit or payment, or made for use in determining rights to such benefit or payment, which, if false, subjects the Provider to termination from the WCDP along with any other remedies under law.

Name — Provider		
Title — Provider	Provider ID	
Address — Provider's Physical Location		
Address Line 1		Address Line 2
City	State	ZIP+4 Code
SIGNATURE — Provider		Date Signed — Provider
FOR DHCAA USE ONLY (Do not write below this line)		
SIGNATURE		DATE

**BOTH PAGES OF THIS PROVIDER AGREEMENT AND ACKNOWLEDGEMENT
MUST BE RETURNED TOGETHER.**

**FORWARDHEALTH
ELECTRONIC BILLING GENERAL INFORMATION**

ForwardHealth has several electronic billing options available for trading partners to submit electronic claims. Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant software is available at no cost for submitting claims to ForwardHealth. For further information or to order free software refer to www.forwardhealth.wi.gov/ or contact Provider Services at (800) 947-9627 or the EDI Department at (866) 416-4979.

Electronic Methods for Submitting Claims to ForwardHealth

The following are the methods for electronic claim submission:

- Provider Electronic Solutions (PES) — HIPAA-compliant free claim submission software:
 - ✓ 837 Health Care Claim: Institutional.
 - ✓ 837 Health Care Claim: Professional.
 - ✓ 837 Health Care Claim: Dental.
 - ✓ 997 Functional Acknowledgement.
 - ✓ 835 Health Care Claim Payment/Advice.
 - ✓ National Council for Prescription Drug Programs 5.1 Telecommunication Standard for Retail Pharmacy Claims.
- RAS/Internet — Allows providers to send their data files to using a direct RAS connection or Web browser.
- Third-Party Biller — Providers have the option of purchasing a billing system or contracting with a Third-Party Biller to submit their claims.