



Provider Affiliation Change Form

**Steps for
Submission:**

This form is to be used when a practitioner or group has a change in their practice affiliation information.

- 1. Complete the Provider Affiliation Change Form with the most current information and attach a W-9 if applicable.**
- 2. E-mail the form to iCare's Network Development Department (netdev@icare-wi.org) and iCare's Operations Department (operationsprovidermaintenance@icare-wi.org) or please fax the form: 414-272-5618.**

Reason for Submission (Required):

Adding Provider to Practice

Terminating Provider from Practice

Provider Demographics On File (Required):

Practice Name:

Tax Identification
Number:

National Practitioner
Identifier (NPI):

New Provider Demographics (Check Box for Practice or Practitioner)

Practice

Practitioner

Provider Name:

Effective Date:

National
Practitioner
Identifier (NPI):

Tax Identification
Number:

Licensure:

Medicare :

Medicaid :

Specialty:

Accreditation:

Languages
Spoken:

Office
Hours:

Practice Address

New Address

Terminate Address

Street:

Suite:

City:

State:

ZIP:

E-mail:

Telephone:

Fax:

Office
Hours :

Billing Address

New Address

Terminate Address

Street:

Suite:

City:

State:

ZIP:

E-mail:

Telephone:

Fax:

Office
Hours :

Contact Information

Requestor
Name:

Requestor
E-mail:

Telephone:

Fax:

Electronic
Signature:

Date:

Comments:

If you prefer to complete this form manually, please submit to:

Independent Care Health Plan
Attn: Network Development
1555 N Rivercenter Drive, Suite 206
Milwaukee, WI 53212
Fax: 414-272-5618