



Please submit completed application to iCare's Provider Updates (providerupdates@icare-wi.org) or fax to 414-272-5618
INCOMPLETE APPLICATIONS RECEIVED WILL NOT BE REVIEWED

Section I: Provider Identification (For additional locations, please complete Section III)

| | | | |
|---|-------------|----------------------------------|-------------|
| Provider Legal Entity Name (must match W-9 and associated TIN): | | | |
| Doing Business as Name (dba) if applicable: | | | |
| Provider Street Address: | | City: | State: Zip: |
| Provider Phone Number: | Fax Number: | Tax Identification Number (TIN): | |
| National Provider Identifier (NPI) (if applicable): | | Medicaid ID# (if applicable): | |
| Contract Signor Information: | | | |
| Contract Signor Name: | Title: | Contract Signor Phone Number: | |
| Contract Signor Email Address: | | | |
| Contact Information: | | | |
| Contract Name: | Title: | Contact Phone Number: | |
| Contact Email Address: | | | |
| Billing Information | | | |
| Checks Payable to (Billing Name): | | Billing Address: | |
| Online Provider Portal Access Information sent upon completion of contract: <input type="checkbox"/> Email: <input type="checkbox"/> USPS Address: | | | |
| Credentialing Contact Information: <input type="checkbox"/> Check if same as Contact Information | | | |
| Contact Name: | Title: | | |
| Phone Number: | Fax Number: | Email Address: | |
| Preferred Method of Contact (if not checked, default will be Email): <input type="checkbox"/> Email <input type="checkbox"/> Fax | | | |

Section II: Requested Documents (For Each Location as Applicable)

| Required Documents | Applicable/Attached | | |
|---|-----------------------------|--------------------------|--------------------------|
| Completed W-9 Form | Required for all Applicants | | |
| Face Sheet of Current Business Liability Insurance | Required for all Applicants | | |
| Copy of practitioner roster, please include name, NPI, and license type | Required for all Applicants | | |
| Additional Document(s) Needed (if applicable) | Yes | No | N/A |
| Copy(s) of all Federal, State, and/or local professional licenses, certifications, and/or registrations specifically required to operate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Copy(s) of all Federal, State, and/or local business licenses, certifications, and/or registrations specifically required to operate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Copy(s) of all Accreditation Certificates and the most recent survey results | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Copy(s) of the most recent CMS survey, including a corrective action plan if deficiencies were cited and evidence from CMS that all deficiencies are remedied | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Copy(s) of the most recent DQA survey, including a corrective action plan if deficiencies were cited and evidence from DQA that all deficiencies are remedied | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Section III must be completed for each location

| | | |
|-----------------------------|----------------|--|
| Location #: | | |
| Name (& dba if applicable): | | Address: |
| Phone Number: | Fax Number: | NPI (if applicable): |
| Contact Person/Title: | Email Address: | Language(s) spoken other than English: |

| | |
|--|--|
| Wheelchair Accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No | Electronic Health Records (EHR): <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Accepting New Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No | Same Day Appointments: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Population Served: <input type="checkbox"/> Children: Starting Age: <input type="checkbox"/> Adolescents <input type="checkbox"/> Adults <input type="checkbox"/> Seniors | |

| Location Hours | | | | | | |
|----------------|--------|---------|-----------|----------|--------|----------|
| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
| | | | | | | |

| Licensure, Certifications or Accreditation (if applicable): | Number | Effective Date | Expiration Date | Date of Last Full Survey | Any Deficiencies |
|--|--------|----------------|-----------------|--------------------------|--|
| Medicaid Provider | | | | | |
| Medicare Provider | | | | | |
| Wisconsin DQA Certified/Licensed? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CMS Survey (if applicable) | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Accrediting Organization | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Memberships/Certifications | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has this facility ever been revoked or denied any of the above? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please describe in detail any "Yes" responses on a separate sheet or letterhead. Please identify location number as listed for Section III, sign and date each attachment submitted.

| | | |
|---|--|---|
| Location Specialty Services: (check all that apply) | <input type="checkbox"/> Adolescent/ Child Psychotherapy <input type="checkbox"/> Addiction Disorders <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> AODA Treatment (Outpatient) <input type="checkbox"/> AODA Day Treatment- DHS 75.12 <input type="checkbox"/> Art/ Music Therapy <input type="checkbox"/> Biofeedback <input type="checkbox"/> Crisis Center <input type="checkbox"/> Community Support Program (CSP)- DHS 63 <input type="checkbox"/> Competency Testing <input type="checkbox"/> Depression <input type="checkbox"/> Developmental Testing/ Screening <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Family Psychotherapy <input type="checkbox"/> Gender Identity <input type="checkbox"/> Geriatric Psychotherapy <input type="checkbox"/> Grief Counseling <input type="checkbox"/> Group/ Family Psychotherapy | <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Hypnotherapy <input type="checkbox"/> Individual Psychotherapy <input type="checkbox"/> Inpatient Mental Health Treatment <input type="checkbox"/> Intensive Outpatient Program (IOP) <input type="checkbox"/> Intensive Outpatient Therapy <input type="checkbox"/> Medication Management <input type="checkbox"/> Mental Health Day Treatment- DHS 75.12 <input type="checkbox"/> Methadone Treatment <input type="checkbox"/> Mood Disorders <input type="checkbox"/> Neuropsychological Testing <input type="checkbox"/> Personality Disorders <input type="checkbox"/> PTSD <input type="checkbox"/> Psychiatry <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Psychological Testing <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Suboxone Treatment <input type="checkbox"/> Traumatic Brain Injury (TBI) |
|---|--|---|

Counties Served:

Section IV: Exclusion Certification

I hereby certify the online exclusion list for Health and Human Services, Office of Inspector General (OIG) is checked for all new hires and at least quarterly for existing employees to ensure that no excluded employees work in any capacity related to any state or federal health care program. I understand that Managed Care Organizations are precluded from contracting with providers who have been excluded from participation in any state or federal health care program. I also hereby certify that I will remove any employee found on one of the above referenced list from any work related to any state or federal health care program.

Section V: Attestations Questions

Please answer the following questions “Yes” or “No.” If your answer to any of the following questions is “Yes,” please provide details and reasons, as specific to each question, on a separate sheet or letterhead. Please sign and date each additional sheet submitted. Provider attests that as it relates to the facilities and services selected:

| | |
|--|--|
| Has this provider, under any current or former business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with delivery of a health care item or service? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to fraud, theft, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has this provider, under any current or former name or business identity, ever had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has this provider, under any current or former name or business identity, ever had accreditation revoked or suspended? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has this provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive procurement or non-procurement program? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is this provider, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Signature of Authorized Representative

Printed Name of Authorized Representative

Authorized Representative’s Title

Date Signed

Section VI: Attestation

Agency attests that as it relates to the facilities and services selected:

| | |
|---|--|
| Has verified qualifications of each staff member, including academic preparation and relevant experience. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has proof of all permits, licenses and certifications, required of staff members, to perform the duties of their position. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Maintains a training plan for each staff member and has a mechanism for ensuring that all necessary training has been completed <i>prior</i> to performing work. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Completes Caregiver Background Checks on all employees <i>prior</i> to the employee providing direct services to Member, and every four (4) years thereafter or any time that entity has a reason to believe that a new check should be obtained. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has a mechanism to track the completion of Caregiver Background Checks to ensure compliance with the requirements in the iCare LTC contract. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Maintains the results on its premises for at least the duration of the LTC contract with iCare. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

The individual identified below acknowledges that they have reviewed the statements above and attests that the information herein be true and accurate.

Signature of Authorized Representative

Printed Name of Authorized Representative

Authorized Representative's Title

Date Signed

AUTHORIZATION FOR RELEASE OF INFORMATION AND ATTESTATION

The organization identified below (hereinafter “the Organization”) has applied to be a participating provider with Independent Care Health Plan (iCare). In order for iCare to evaluate the Organization’s qualifications, Organization authorizes iCare and its authorized representatives and agents to consult with any third party who may have information (including information that otherwise may be privileged or confidential) relating to the qualifications, competence and conduct of said Organization. Organization also authorizes any such third party (including the credentials verification organization) to release such information, related reports and documents to iCare and its authorized representatives and agents upon request and receipt of a copy of this Authorization for Release of Information.

The undersigned certifies that all information in the Organization’s application is warranted to be true, accurate and complete. Organization also agrees to immediately update iCare on any changes in the information submitted in the application and agrees to provide such additional information and execute such additional forms as may be requested by iCare in order to evaluate the Organization’s qualifications, competence and conduct.

As an applicant for credentialing or recredentialing with iCare, Organization has the right to review the information submitted in support of the credentialing application. Organization acknowledges that iCare will notify the Organization of any information obtained during the credentialing process that varies substantially from the information provided by Organization to iCare and that it will have the right to correct any and all erroneous information in the application.

By submitting an application for credentialing or recredentialing with iCare, Organization agrees to be bound by the terms of the credentialing program, as it may be amended by iCare from time to time. Organization understands that iCare will use this information solely in conjunction with the application for and status as a participating provider and that the information is not subject to re-disclosure except as permitted by Federal and State Law.

Organization hereby releases from liability iCare and its directors, officers, employees and authorized representatives, including the credentialing agent, its directors, employees, representatives, agents and third parties for any acts performed in good faith in providing or receiving information, reports or other documents relating to or in evaluating Organization’s professional qualifications, competence or conduct. This release from liability shall include but not be limited to, actions related to the following:

- Organization’s application to be a participating provider with iCare.
- Periodic appraisals undertaken for recredentialing, utilization review or otherwise for quality management; and
- Proceedings for termination, suspension or restriction of the Organization’s status as a participating provider with iCare or any other disciplinary action.

This authorization is valid for 365 days and if the Organization becomes an iCare participating provider, for the time period that the Organization remains an iCare provider.

Signature of Authorized Representative

Printed Name of Authorized Representative

Authorized Representative’s Title

Date Signed

Print Name of Organization