INDEPENDENT CARE HEALTH PLAN

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 providerupdates@icare-wi.org and operationsprovidermaintenance@icare-wi.org. If you cannot email the form, please fax the changes to: 414-272-5618**

Reason for Submission (Required):

☐ Adding Provider to Practice ☐ Terminating Provider from Practice

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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