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: ☐Email: ☐USPS Address:			
Credentialing Contact Information: ☐ 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): ☐ Email ☐ 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			
Copy(s) of all Federal, State, and/or local **business** licenses, certifications, and/or registrations specifically required to operate			
Copy(s) of all **Accreditation Certificates** and the most recent survey results			
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			
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			

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: ☐Yes ☐No	**Electronic Health Records (EHR): ☐Yes ☐No**
Accepting New Patient: ☐Yes ☐No	**Same Day Appointments: ☐Yes ☐No**
Population Served: ☐ Children: Starting Age: ☐ **Adolescents** ☐ **Adults** ☐ **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?					☐Yes ☐No
CMS Survey (if applicable)					☐Yes ☐No
Accrediting Organization					☐Yes ☐No
Other Memberships/Certifications					☐Yes ☐No
Has this facility ever been revoked or denied any of the above?					☐Yes ☐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)		
	☐ Adolescent/ Child Psychotherapy ☐ Addiction Disorders ☐ Anxiety Disorder ☐ AODA Treatment (Outpatient) ☐ AODA Day Treatment- DHS 75.12 ☐ Art/ Music Therapy ☐ Biofeedback ☐ Crisis Center ☐ Community Support Program (CSP)- DHS 63 ☐ Competency Testing ☐ Depression ☐ Developmental Testing/ Screening ☐ Eating Disorders ☐ Family Psychotherapy ☐ Gender Identity ☐ Geriatric Psychotherapy ☐ Grief Counseling ☐ Group/ Family Psychotherapy	☐ Hearing Impaired ☐ Hypnotherapy ☐ Individual Psychotherapy ☐ Inpatient Mental Health Treatment ☐ Intensive Outpatient Program (IOP) ☐ Intensive Outpatient Therapy ☐ Medication Management ☐ Mental Health Day Treatment- DHS 75.12 ☐ Methadone Treatment ☐ Mood Disorders ☐ Neuropsychological Testing ☐ Personality Disorders ☐ PTSD ☐ Psychiatry ☐ Psychiatric Evaluation ☐ Psychological Testing ☐ Schizophrenia ☐ Suboxone Treatment ☐ 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?	☐Yes ☐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?	☐Yes ☐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?	☐Yes ☐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.	☐Yes ☐No
Has this provider, under any current or former name or business identity, **ever** had accreditation revoked or suspended?	☐Yes ☐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?	☐Yes ☐No
Is this provider, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number?	☐Yes ☐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.	☐Yes ☐No
Has proof of all permits, licenses and certifications, required of staff members, to perform the duties of their position.	☐Yes ☐No
Maintains a training plan for each staff member and has a mechanism for ensuring that all necessary training has been completed *prior* to performing work.	☐Yes ☐No
Completes Caregiver Background Checks on all employees *prior* 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.	☐Yes ☐No
Has a mechanism to track the completion of Caregiver Background Checks to ensure compliance with the requirements in the iCare LTC contract.	☐Yes ☐No
Maintains the results on its premises for at least the duration of the LTC contract with iCare.	☐Yes ☐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 (*i*Care). In order for *i*Care to evaluate the Organization's qualifications, Organization authorizes *i*Care 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 *i*Care 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 *i*Care 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 *i*Care in order to evaluate the Organization's qualifications, competence and conduct.

As an applicant for credentialing or recredentialing with *i*Care, Organization has the right to review the information submitted in support of the credentialing application. Organization acknowledges that *i*Care will notify the Organization of any information obtained during the credentialing process that varies substantially from the information provided by Organization to *i*Care 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 *i*Care, Organization agrees to be bound by the terms of the credentialing program, as it may be amended by *i*Care from time to time. Organization understands that *i*Care 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 *i*Care 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 *i*Care.
- 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 *i*Care or any other disciplinary action.

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

_____ _____

Signature of Authorized Representative Printed Name of Authorized Representative

_____ _____

Authorized Representative's Title Date Signed

_____

Print Name of Organization