Practitioner Form Help

The Practitioner Notification Form is for our participating providers that are currently in our network. If your facility is interested in joining our network, please complete the Provider Participation Request Form.

Add Practitioner: Select this option if a practitioner is joining your organization.

Start Date: Effective date for practitioner
Tax ID: The nine-digit identification number used by the Internal Revenue Service in the administration of tax laws for this practitioner
Last Name: The last name of the individual practitioner as listed on state license where care is being rendered
First Name: The first name of the individual practitioner as listed on state license where care is being rendered
Middle Initial: The middle initial of the individual practitioner as listed on state license where care is being rendered
Credential / Degree: Credential(s) or degree(s), representing education and ability to provide care, awarded to the healthcare practitioner
Date of Birth: Practitioner Date of birth
Gender: Select the appropriate gender for the new practitioner
Race: Chose the appropriate value from the dropdown associated with the practitioner’s race
Ethnicity: Chose the appropriate value from the dropdown associated with the practitioner’s ethnicity
Spoken Languages: Using the dropdown select **a**ll languages in which the practitioner is fluent
Cultural Competency Training: Mark yes or no if the practitioner has completed cultural competency training
Practitioner’s Email: Enter the practitioner’s email address
License Section
In Training or non-licensed? Indicate if the practitioner holds an in training or temporary licensure
Practitioner NPI: The unique 10-digit identification number assigned to the new health care practitioner
License Type: The occupational licensure of the practitioner (ex: physician, physical therapist, licensed clinical social worker, etc.)
License Number: The identifying number given on the state license to the physician by the state medical board
License State: State in which the practitioner is licensed to practice
License Expiration Date: The date in which the practitioner's license expires, if not removed
Is this provider Medicare certified? Yes or No; If yes complete all applicable fields
Is this provider Medicaid certified? Yes or No; If yes complete all applicable fields
Is the rendering provider’s NPI billable for BadgerCare members? Yes or No – indicate if the practitioner is Medicaid certified to both render services and bill for services
Facilities
Primary Location: Select this next to the primary location at which the practitioner practices
Facility Name: Name of each clinic, hospital or other facility where practitioner will be seeing members
Address: Physical address associated with each facility location
City: City associated with each facility location
State: State associated with each facility location

Zip: Zip Code associated with each facility location (must include four-digit extension)
County: County in which each facility is located
Phone: Telephone number associated with each facility location
Clinical or Referral / Authorization Fax: Fax number for submission of referrals or authorization documentation for each location
Select PCP and / or Specialist: PCP denotes that members can select the practitioner as their primary care physician; specialist indicates the practitioner is not providing primary care services
Practitioner Status: Select the status that best describes practitioner from the drop-down menu
Specialty: Select the applicable specialty from the drop-down menu
Treatment Interests: Required for Behavioral Health Providers. Select the appropriate treatment interests from the drop-down menu
Taxonomy Code: Code description that most closely describes the practitioner's type / classification / specialization for purpose of rendering health care. If applicable, enter more than one code description in order to adequately describe the type / classification / specialization
Should the provider be listed in the directory? Yes or No
Available as a PCP? Yes or No
Accepting New Patients? Yes or No
Hospital Affiliations
List all hospitals where practitioner has Hospital Privileges: Hospital(s) where the practitioner has been granted privileges
Hospital Name: Enter the hospital name
Hospital Address: Enter the hospital address
City: Enter the city in which the hospital is located
State: Enter the state in which the hospital is located
Zip: Enter the zip associated with the hospital
Practitioner Billing Information
Billing Name: Complete legal name of organization or corporate entity
Billing Address: Street address associated with billing organization
City: City associated with billing address
State: State associated with billing address
Zip: Zip Code associated with billing address (must include four-digit extension)
Billing NPI: The unique 10-digit identification number for covered health care providers. If practitioner will be submitting charges under more than one NPI, submit a separate New Practitioner Form for each billing NPI
Taxonomy Code: Code description that most closely describes the practitioner's type / classification / specialization for purpose of rendering health care. If applicable, enter more than one code description to adequately describe the type / classification / specialization
Practitioner Employed by Organization? Yes or No
Comments: List any applicable information not requested above
Credentialing Recipient: Name of the contact who should receive credentialing materials
Address: The number and street where credentialing materials should be mailed
City: City associated with credentialing recipient
State: State associated with credentialing recipient
Zip: Zip Code associated with credentialing recipient
Phone: Telephone number associated with the credentialing recipient
Fax: Fax Number associated with the credentialing recipient
Email Address: Email Address associated with the credentialing recipient

Completed by: Name of the individual completing this form. Individual must be authorized to represent the provider office for enrollment with health insurance payers
Email Address: Email address of the individual completing the form
Phone: Telephone number for the individual completing the form

Updating Practitioner: Complete this option if an existing practitioner with your organization is adding or terming a practice location, when a practitioner changes their name, specialty, degree/credentials, licensure, or status at a practice location such as no longer accepting new patients.

Clinic Name: Current name of clinic, hospital, or other facility
Tax ID: The nine-digit identification number used by the Internal Revenue Service in the administration of tax laws for this provider or practitioner
Billing NPI: The unique 10-digit identification number for each covered health care providers. List all applicable NPIs.
Practitioner Name (if applicable): Name of each practitioner that has a change in information
Practitioner NPI: If applicable, the unique 10-digit identification number assigned each to health care practitioner with a change in information
Effective Date: Effective date of change
Reason for Change: Select the item that best describes the reason for change from the drop-down list
Change Request: Description of change being reported (for example: practitioner name change, address change, status change, adding OB services, etc.)
Adding a practice location to an existing practitioner? Complete this section if adding a practice location to an existing practitioner
Terminating a practice location for an existing practitioner? Complete this section if adding a practice location to an existing practitioner
Updating Practitioner Information (Name Change, Degree Change)? Complete this section if updating practitioner name or credentials/degree
Change in Licensure? Complete this section if adding updating a practitioner licensure
Update Hospital Affiliations? Complete this section if updating hospital affiliations associated with an existing practitioner
Completed by: Name of the individual completing this form. Individual must be authorized to represent the provider office for enrollment with health insurance payers
Email Address: Email address associated with contact
Phone: Telephone number associated with contact

Terminating Practitioner: Complete this option if an existing practitioner is completely terminating from your organization for all practice locations.

Practitioner Last Name: The last name of the individual practitioner as listed on the state license where care is being rendered
Practitioner First Name: The first name of the individual practitioner as listed on the state license where care is being rendered
Practitioner Middle Initial: The middle initial of the individual practitioner as listed on the state license where care is being rendered
Practitioner NPI: The unique 10-digit identification number assigned to the health care practitioner being terminated
Termination Date: The last date the terminating practitioner is eligible to see patients or employed by organization

What location(s) is practitioner terminating from? The name of the facility or facilities from which the practitioner is terminating
Practicing Site Name / City: Name and address of location(s) practitioner will continue to practice, if applicable
Billing NPI: The unique 10-digit identification number for covered health care providers
Tax ID: The nine-digit identification number used by the Internal Revenue Service in the administration of tax laws for this practitioner
If practitioner is a Primary Care Physician, who will be taking members currently assigned to practitioner? The first and last name of the primary care physician(s) who will continue care for impacted members
If practitioner is a Specialist, who will be taking referrals that were assigned to practitioner? The first and last name of the specialist provider(s) who will continue care for impacted members
How will members be notified of this change? List all communication methods utilized to notify members of terminating practitioner
If this was the only practitioner at the site, will the practitioner be replaced? Select Yes or No
If so, when? Enter the effective date for the replacement practitioner
Where will the terminating practitioner be going (required by Wis. Law)? If known, provide the organization or facility name to which the terminating practitioner is relocating. If unknown, state "unknown"
Why is practitioner leaving? Select of the choice that best describes the reason the practitioner is leaving from the drop-down list
Completed by: Name of the individual completing this form. Individual must be authorized to represent the provider office for enrollment with health insurance payers
Email Address: Email address of the individual completing the form
Phone: Telephone number associated with contact