



Confidential

1617 Sherman Ave.
 Madison, WI 53704
 (800) 963-0035
 Fax: (414) 287-7704
www.mychoicewi.org

NEW FACILITY AND/OR SERVICE LOCATION FORM

Please complete the form below for each location you would like added. If there is a Tax ID change, please include a W9.

Additional Facility/Service Location					
Location Name		Effective Date		Service Location Type: <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Clinic <input type="checkbox"/> Rural Health Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Critical Access Hospital <input type="checkbox"/> Institute for Mental Disease <input type="checkbox"/> Long-Term Acute Care Hospital <input type="checkbox"/> Acute Care Hospital <input type="checkbox"/> Psychiatric Unit <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Other:	
Street Address					
City		State			
Zip Code	County	Print in Directory <input type="checkbox"/> Yes <input type="checkbox"/> No			
Site Phone Number		Site Fax Number			
Medical Records Fax Number					
Site Contact Name and Title		Site Contact E-mail Address		Taxpayer Number	
Wisconsin License Number	National Provider Identifier (NPI)		Medicaid Number	Medicare Number	
Languages other than English spoken? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," list languages here:		Does your facility perform lab draws: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provide CLIA Number: (Clinical Laboratory Improvement Amendments)			
Pay Directly to this Address? <input type="checkbox"/> Yes <input type="checkbox"/> No *If No, fill out Billing Information		Handicap Accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Check here if this is N/A because this site provides services to members in their own settings			
Billing Street Address				Billers NPI	
Billing City		Billing State	Billing Zip Code		Billing County
Billing Contact Name and Title		Billing Contact E-mail Address		Billing Phone Number	Billing Fax Number
Services Provided at this Location:					
<input type="checkbox"/> AODA	<input type="checkbox"/> Hospice*		<input type="checkbox"/> Prosthetics		
<input type="checkbox"/> AODA (Day Treatment)	<input type="checkbox"/> Laboratory Services		<input type="checkbox"/> Radiology		
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Meals (Home Delivered)		<input type="checkbox"/> Skilled Nursing		
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Mental Health		<input type="checkbox"/> Speech Therapy		
<input type="checkbox"/> Dental Services	<input type="checkbox"/> Mental Health (Day Treatment)		<input type="checkbox"/> Swing Bed		
<input type="checkbox"/> Durable Medical Equipment*	<input type="checkbox"/> Occupational Therapy		<input type="checkbox"/> Vision-Optical		
<input type="checkbox"/> Durable Medical Supplies	<input type="checkbox"/> Orthotics		<input type="checkbox"/> Vision-Optometry/Ophthalmology		
<input type="checkbox"/> Hearing Aids/Services	<input type="checkbox"/> PERS (Lifeline)		<input type="checkbox"/> Other:		
<input type="checkbox"/> Home Health Services*	<input type="checkbox"/> Physical Therapy		<input type="checkbox"/> Other:		
<input type="checkbox"/> Home Infusion	<input type="checkbox"/> Primary & Specialty Care		<input type="checkbox"/> Other:		
*Counties served by Durable Medical Equipment:					
*Counties served by Home Health:					
*Counties served by Hospice:					

Questions? Please contact our Provider Services Department at 1-800-963-0035

To add an additional provider, please complete the form below or attach a separate list of additional practitioners to be added, and include the following information for each practitioner:

	Practitioner 1	Practitioner 2	Practitioner 3	Practitioner 4
Practitioner Name				
Degree				
Specialty				
Board Certification Type				
PCP (Y/N)				
NPI Number				
Medicaid Number				
Medicare Number				
License Number				
Print in Directory (Y/N)				
Accepting New Patients (Y/N)				
Location Name				
Effective Date at Location				

Please return your completed application to our Provider Services Department:

By Fax: 414-287-7704 – Attn: Provider Services Credentialing

By Email: credentialing@mychoicefamilycare.com – Subject:

Additional Location Form