Children's Community Health Plan
P.O. Box 1997, MS6280
Milwaukee, WI 53201-1997
Provider Relations: 844-229-2775
childrenscommunityhealthplan.org

Letter of Interest Form

Please read before you begin:

- If you're a *current* network provider group and want to add an individual provider, you will need to submit a credentialing application first. Information about our credentialing process is on our website.
- If you're a *new* provider group or an individual provider interested in contracting with Children's Community Health Plan, please complete this form by answering the following questions. This information will help us determine if your qualifications align with the service needs of our network.
- Important: Please include your W-9 form with your submittal of this questionnaire.
- Email completed form and W-9 form to CCHP Provider Relations at CCHP-Contracting@chw.org.

(* = Indicates a required field)

Demographic information

Type of practice/group: INDIVIDUAL GROUP **Specialty:**

***Practice/Group name:**

***Physical address:**

Number and street name (include suite if applicable) City State ZIP

***Billing address:**

Number and street name (include suite if applicable) City State ZIP

***Office phone:** **Fax:**

***Names of providers practicing with group:**

***Federal tax ID:**

***Group National Provider Identifier (NPI) 2:**

***Individual NPI 1:**

***Are ALL providers in group state of Wisconsin Medicaid certified?** ☐ YES ☐ NO

***Is anyone in your practice unable to bill Wisconsin Medicaid due to being investigated for fraud?** ☐ YES ☐ NO

***Please list any accreditations:**

Which hospitals do you have admitting privileges?

Contact person for completion of credentialing paperwork

***Name:** ***Email:**

Provider services information

What services do you provide in your office?

In addition to English, what languages do you speak in your office? ☐ SPANISH ☐ HMONG OTHER:

What type of patients do you treat? ☐ CHILDREN ☐ ADULTS ☐ PREGNANT WOMEN

***Office hours:**
(List all days & all hours your practice is open, i.e., M8am-5pm; Tu10am-5pm; W9am-6pm)

What other Medicaid plans are you enrolled?

***Is your office wheelchair accessible?** ☐ YES ☐ NO

PC021601 (Rev.03/2016).

Letter of Interest Form (continued)

Primary Care provider services information

If you're a primary care provider (PCP), please answer the following questions.

If a PCP, do you provide EPSDT services? ☐ YES ☐ NO

If a PCP, do you participate in the Vaccines for Children program? ☐ YES ☐ NO

Behavioral Health provider services information

If you're a Behavioral Health provider, please answer the following questions.

Are you able to schedule a patient visit within seven days of discharge from an inpatient facility? ☐ YES ☐ NO

***Do you provide day treatment?** ☐ YES ☐ NO ☐ Children/adolescents (under age 18) ☐ Adults (age 18 and older)

Upon completion of this form

- Please review all the answers and information you provided and make sure it's all correct
- Attach your W-9 form along with this questionnaire and email it to CCHP Provider Relations at CCHP-Contracting@chw.org
- If approved, CCHP will mail you a Provider Network Agreement form, along with credentialing information within a few weeks of receiving your submittal

We're here to help

If you need assistance completing your Letter of Interest form or have questions about your Provider Network Agreement, please contact CCHP Provider Relations Representative Tina Thomas by email at tthomas@chw.org.

Notes: