Children's Community Health Plan

PO Box 1997, MS 6280
Milwaukee, WI 53201-1997
www.childrenscommunityhealthplan.org

Letter of Interest Form

Please read before you begin:

- This form should be ONLY used for new provider groups or individual practitioners interested in contracting with Together with CCHP and / or BadgerCare Plus – CCHP. 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 and insurance.
- Email completed form and W-9 form to Provider Relations at CCHP-Contracting@chw.org.
- To enroll a chiropractic provider in the Together with CCHP network please contact Wisconsin Health Choice at 262-201-4327.

SECTION 1 – DEMOGRAPHIC INFORMATION *(* = Indicates a required field)*

Type of Practice: ☐ Individual ☐ Group

Provider Type: ☐ PCP ☐ Specialist ☐ Hospital ☐ Behavioral Health ☐ Other

Interested in ☐ BadgerCare Plus ☐ Together with CCHP ☐ Both plans

*PRACTICE GROUP NAME: OFFICE PHONE NO. OFFICE FAX NO.

*PRACTICE ADDRESS CITY STATE ZIP

*BILLING ADDRESS CITY STATE ZIP

BILLING PHONE NO. BILLING FAX NO.

*Name of providers practicing at this group:

*Please list any accreditations:

Please list any hospitals you have admitting privileges:

*Federal Tax ID: *Group NPI Identifier 2: *Individual NPI 1:

*Contact person for completion of credentialing paperwork: Name:

Email

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SECTION 2 – PROVIDER SERVICES INFORMATION

What service do you provide in your office?

In additional 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 in the days and hours the practice is open)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

If your office wheelchair accessible? ☐ Yes ☐ No

Primary Care Provider Services Information

If you are a primary care provider (PCP), please answer the following questions:

Do you provide EPSDT services? ☐ Yes ☐ No

Do you participate in the Vaccines for Children Program? ☐ Yes ☐ No

Behavioral Health Providers 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 (over age 18)

Upon completion of this form:

- Please review all the answers and information you provided is correct
- Attach your W-9 form along with this questionnaire and email it to Provider Relations at CCHP-Contracting@chw.org
- If approved, Children's Community Health Plan will email you a Provider Network Agreement within 30 days of receiving the letter of interest.
- Please attach a copy of the facility's insurance certificates including insurer affording coverage, policy number, effective date and expiration date