

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

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

Is your office wheelchair accessible? Yes No

Do you provide telehealth services? Yes (An onsite visit will need to be scheduled with credentialing) 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