



PO Box 1997, MS 6280
 Milwaukee, WI 53201-1997
 Toll-free: 1-800-482-8010
www.childrenscommunityhealthplan.org

Practitioner Credentialing Request Form

Please complete this form to request credentialing for an individual practitioner and email it to cchp-credentialing@chw.org

***Required fields in bold.**

Requestor's Name:		Phone:	
Title:		Email:	
Practice Name:			
Practice Address:			
City:	State:	Zip:	
Phone:	Fax:	TIN:	
Practitioner Name:		NPI:	CAQH#:
Licensure#:		Specialty:	
Other Lic#	Collaborative Physician (for APNPs only):		
<i>Additional Practice Location</i>			
Address:			
City:	State:	Zip:	
Phone:	Fax:	Email:	
<i>Additional Practice Location</i>			
Address:			
City:	State:	Zip:	
Phone:	Fax:	Email:	
Comments:			

Please submit any questions to the email addresses listed above. Thank you.