



We care for Wisconsin.
 UNDERWRITTEN BY WPS HEALTH PLAN, INC.

Facility Data Sheet

Please use this form to notify Arise Health Plan of any changes, additions, or terminations within your organization.

Please return form and copy of W-9 to:

Network Development Department
 Arise Health Plan, PO Box 11625, Green Bay, WI 54307-1625
 FAX: (920) 490-6923
 Email: GBNetworkDevelopmentDept@arisehealthplan.com

Contact Information			
Contact Name			
Organization			
Address			
City, State, Zip			
Telephone Number		Fax Number	
Email Address			

SECTION A – ADD FACILITY (Include copy of W-9)

Facility information			
Location Name			
Address			
City, State, Zip			
County			
Telephone Number		Fax Number	
Facility NPI		License #	
Medicare #		Medicaid #	
Effective Date			

Mailing address (if different than above)			
Attention to:			
Organization			
Mailing Address			
City, State, Zip			
Telephone Number		Fax Number	
Email Address			

Billing information			
Name on 1099 Tax Form			
Federal Tax ID			
Remit to Name			
Address			
City, State, Zip			
Telephone Number		Fax Number	

Credentialing contact:

Name			
Address			
City, State, Zip			
Telephone Number		Fax Number	
Email address			

Please indicate your facility type/services by checking the appropriate box(es):

<input type="checkbox"/>	Ambulatory Surgery Center	<input type="checkbox"/>	Hospital Based Psychiatric Unit
<input type="checkbox"/>	Arrhythmia Monitoring/Cardiac Monitoring	<input type="checkbox"/>	Laboratory*
<input type="checkbox"/>	Audiology	<input type="checkbox"/>	Mammography
<input type="checkbox"/>	Behavioral Health Facility	<input type="checkbox"/>	Magnetic Resonance Imaging
<input type="checkbox"/>	Breast Prosthetics	<input type="checkbox"/>	Occupational Therapy
<input type="checkbox"/>	Clinic	<input type="checkbox"/>	Pain Management
<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	Drug and Alcohol Facility – Outpatient	<input type="checkbox"/>	Prosthetics/Orthotics
<input type="checkbox"/>	Drug and Alcohol Services – Inpatient	<input type="checkbox"/>	Radiology Services*
<input type="checkbox"/>	Durable Medical Equipment	<input type="checkbox"/>	Rehabilitation Facility
<input type="checkbox"/>	EEG & Sleep Studies	<input type="checkbox"/>	Skilled Nursing Facility
<input type="checkbox"/>	Home Health Care	<input type="checkbox"/>	Speech Therapy
<input type="checkbox"/>	Home Infusion	<input type="checkbox"/>	Transitional Rehabilitation Unit
<input type="checkbox"/>	Hospice	<input type="checkbox"/>	Urgent Care Facility
<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Wound Vac Therapy
<input type="checkbox"/>	Hospital Based Urgent Care		

**Will not appear in directory listings*

SECTION B – FACILITY CHANGE/TERM (Include copy of updated W-9)

Facility Information	Old Location	New Location OR ✓ if this location is now closed <input type="checkbox"/>
Facility Name		
Address		
City, State, Zip		
Telephone Number		
Fax Number		
Effective Date		

Network Development Dept	Database		Date Sent to Cred Dept		Initials	
Credentialing Dept Use Only	Database		Date Application Sent		Initials	