



Practitioner 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			
Name			
Organization/Clinic			
Address			
City, State, Zip			
Telephone Number		Fax Number	
Email Address			

<input type="checkbox"/>	PRACTITIONER ADD/CHANGE	Please fill in Section A
<input type="checkbox"/>	PRACTITIONER TERM	Please fill in Section B
<input type="checkbox"/>	CLINIC SITE CHANGE/TERM	Please fill in Section C

SECTION A – ADD/CHANGE PRACTITIONER New practitioner Change to existing practitioner

Practitioner information			
Full Name			
Professional Designation(s)			
Date of Birth		Gender	
Specialty			
NPI		License #	
Medicare #		Medicaid #	
Social Security Number			
Language(s) spoken			

Practice information	If Existing Practitioner: <input type="checkbox"/> Add practice location <input type="checkbox"/> Term practice location		
Clinic Name			
Address			
City, State, Zip			
Telephone Number		Fax Number	
Expected start/term date			
Primary Office	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mailing Address	<input type="checkbox"/> Yes <input type="checkbox"/> No

****PLEASE LIST ANY ADDITIONAL PRACTICE LOCATIONS ON SEPARATE SHEET**

Billing information			
Pay to the Order Of			
Address			
City, State, Zip			
Telephone Number		Fax Number	
Federal Tax ID		Organization NPI	

If New practitioner – Send credentialing application to:

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

Is this practitioner maintained on CAQH? Yes No

If yes, CAQH Provider ID *Please enable access for Wisconsin Physician Services/ Arise Health Plan*

SECTION B – TERM PRACTITIONER

Practitioner Information	
Full Name	
NPI	License #
Termination Date	
Reason:	
<input type="checkbox"/> Moved/Relocated to:	
<input type="checkbox"/> Retired	
<input type="checkbox"/> Deceased	

SECTION C – CLINIC SITE CHANGE/TERM (Include copy of updated W-9)

Facility Information	Old Location	New Location OR This location is now closed <input type="checkbox"/>
Clinic Name		
Address		
City, State, Zip		
Telephone Number		
Fax Number		
List all practitioners included in this change	Name	Name
Effective Date		

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