

NorthernBridges  
Provider Information Form



Submit form to: NorthernBridges, Attn: Provider Network

Mail: 15954 River's Edge Drive, Hayward, WI 54843 Fax: (715) 934-2268 Email: [providers@northernbridges.net](mailto:providers@northernbridges.net)

Please print or type all responses

Provider Type:

- Service Provider (checkboxes for For Profit Agency, Non-Profit Agency, Government Agency)
Residential Provider (checkboxes for Owner-Occupied, Corporate, Respite, Multiple Locations)
Note: Check all that apply, double click to check.

Contact / Service Information

Contracting Company / Individual Name \_\_\_\_\_

Doing Business As (If applicable): \_\_\_\_\_

Address \_\_\_\_\_ (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip)

Contract Administrator Name \_\_\_\_\_ (administrator name that will be on contract)

Contact Name (If different than Contract Administrator) \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip)

Website \_\_\_\_\_ Office Hours \_\_\_\_\_ Service Hours \_\_\_\_\_

Billing Information

Tax ID# \_\_\_\_\_ (EIN SSN - circle one) NPI# \_\_\_\_\_ (if applicable) WI Medicaid# \_\_\_\_\_ (if applicable)

Billing Company Name \_\_\_\_\_ (name you will use on claims and name that will be on payment checks)

Billing Address \_\_\_\_\_ (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) (address you will use on claims and where payments will be sent)

Billing Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

In receiving this form, NorthernBridges relies on the truth of all the following statements:

- 1. All information entered in all sections of this Provider Information Form is accurate and complete. If any of the information changes, Provider will timely notify NorthernBridges of any such change. Providing false information or omitting information may result in contract denial or termination. Provider also confirms that they are not excluded from participation in Federal health care programs as a provider.
2. Provider knows, understands, and agrees to the certification and service requirements for the applicable provider types for which they desire to provide service.

NOTIFICATION OF CHANGES: You must inform NorthernBridges of any Provider additions and/or changes in licensure, certification, group affiliation, corporate name, ownership, and physical service location or payee address.

Failure to notify NorthernBridges of any changes may result in:

- Misdirected payment
Claim denial, etc.

Authorized Signature of Provider

Date

Signature and Date input fields

## Provider Location and Service Information

Location Name (if different than Provider/DBA Name): \_\_\_\_\_

NPI (if applicable): \_\_\_\_\_ Wisconsin Medicaid # (if applicable): \_\_\_\_\_

Location Address: \_\_\_\_\_  
(street) (city) (state) (zip)

Remit Address: \_\_\_\_\_  
(street) (city) (state) (zip)

Location Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax # (for referrals): \_\_\_\_\_ Email Address: \_\_\_\_\_

County Service Provided in:	<input type="checkbox"/> Ashland	<input type="checkbox"/> Barron	<input type="checkbox"/> Bayfield	<input type="checkbox"/> Burnett
	<input type="checkbox"/> Douglas	<input type="checkbox"/> Iron	<input type="checkbox"/> Polk	<input type="checkbox"/> Price
	<input type="checkbox"/> Rusk	<input type="checkbox"/> Sawyer	<input type="checkbox"/> Washburn	<input type="checkbox"/> All

<b>Target Group(s)</b> (on license/certification)	<b>Facility Accessibility</b>	<b>Service Details:</b> Expertise / Languages / Other
( <input checked="" type="checkbox"/> check all that apply)	( <input checked="" type="checkbox"/> check one)	( <input checked="" type="checkbox"/> check all that apply)
<input type="checkbox"/> DD (developmentally disabled)	<input type="checkbox"/> Wheelchair accessible	<input type="checkbox"/> Memory Care (i.e. Alzheimer's, Dementia, etc...)
<input type="checkbox"/> FE (frail elderly)	<input type="checkbox"/> Not wheelchair accessible	<input type="checkbox"/> Behavioral Health
<input type="checkbox"/> PD (physically disabled)	<input type="checkbox"/> N/A: Member does not receive services on provider premises	<input type="checkbox"/> Language (Please list): _____
<input type="checkbox"/> Mental Illness		<input type="checkbox"/> Other (Please list): _____
<input type="checkbox"/> AODA		

Residential Providers – Bed Capacity: \_\_\_\_\_

### Service Information

(  check all that apply, double click to check)

- Disposable Medical Supplies     Durable Medical Equipment     Therapy
- Physical  
 Occupational  
 Speech

For all other services, please fill in the table below:

HIPAA Code	Service Description	Proposed Rate	Unit
H0046	Mental Health Services	Per MA Fee Schedule	hour