

PROVIDER APPLICATION/CHANGE FORM

- **INSTRUCTIONS:** Type or print your information on this application. If a question does not apply to your application, write "N/A" in the field. Include copies of supporting documentation. **Electronic Copies** of this application and referenced attachments can be found at www.northernbridges.com.

CHECK THE APPROPRIATE BOX:

New Applicant

Change of Information

Date: _____

SECTION I – AGENCY INFORMATION

Instructions:

- **Legal Name:** Enter legal name (e.g., Inc., LLC), if your agency uses a "doing business as" (DBA), then also enter your DBA name.
- **Address:** General information and correspondence will be sent to this address.
- **Remittance/Billing Address:** Enter if billing address is different.
- **TIN:** Taxpayer Identification Number (enter Employer Identification Number-EIN or Social Security Number-SSN if applicable).
- **NPI:** National Provider Identifier Number
- **SPC/HIPAA:** Standard Program Category utilized by Medical Assistance Program for Waiver service descriptions and billing codes related to service provision by HIPAA - refer to Attachment A-1.
- **Multiple Services and/or Locations:** Spaces provided on pages 2, 3 and 4.

Legal Name (Provider Applicant)		Federal TIN	
Address: (Street, City, State, Zip Code)		Website	
SPC number and description (completion of Section II required)		<input type="checkbox"/> For Profit Agency <input type="checkbox"/> Non-Profit Agency <input type="checkbox"/> Government Agency	
Payment Remittance/Billing Address (If different than above)		Billing Contact Information	
Billing Contact Telephone Number		Fax Number	
Name & Title of Person Completing Application		Name of Authorized Contract Signor & Title	
Email Address	Telephone #	Email Address	Telephone #

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

1. All information entered in all sections of this Provider Application 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
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SECTION II – SERVICE PROVIDER GENERAL INFORMATION AND DISCLOSURE QUESTIONS (Attach additional sheets as necessary.)

1. Are you or any of your family members current or past employees of NorthernBridges?
 Yes No If yes, please list:

2. Are you able to begin services when requested within 72 hours? Yes No

3. Are you interested in expanding your capacity provide additional services in the future?
 Yes No If yes, please state which services and by what capacity.

4. Describe your training plan/schedule for your staff:

5. Describe the pay levels and benefits provided for your direct service staff:

6. Describe your organization's policy/process for identifying, reporting, evaluating, correcting, and resolving events and incidents:

SECTION III – PROVIDER DISCLOSURE QUESTIONS

Please provide a complete explanation for any "Yes" answers. Attach additional sheets as necessary.

1. Has your licensure or certification (if applicable) ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing/certification agency or board or any agency or organization, or is there a review pending?
 Yes No

 2. Has your participation (if applicable) in any professional organization ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended, or revoked?
 Yes No
-

NorthernBridges

15954 River's Edge Drive, Suite 300

Hayward, WI 54843

715-934-2266

www.northernbridges.com

3. In the past three years, have you been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action plan with any licensing board, peer review organization, state agency, county agency, or any provider related agency or organization?

Yes No

4. Has your certificate or participation in any private, federal (e.g. Medicare, Medicaid) or state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

Yes No

5. Have you ever been found liable, guilty, or responsible for sexual impropriety or misconduct or sexual harassment with a client, co-worker, or other?

Yes No

6. Have you ever had any liability claims or lawsuits brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments?

Yes No

7. Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to clients and otherwise perform the essential functions of a provider in your area of service provision? If yes, what accommodations would help you provide appropriate care to clients and perform other essential functions?

Yes No

SECTION IV – SERVICE PROVIDER SPC(S) & MULTIPLE LOCATION INFORMATION

SPC code: : _____ HIPAA code: _____		Non MA Service Proposed Rate:	
Service Description: : _____		\$ _____ per _____(hour, day, month, etc.)	
Target Populations Served: (Check all that apply) <input type="checkbox"/> Frail Elders - FE <input type="checkbox"/> Physical Disabilities - PD <input type="checkbox"/> Developmental Disabilities – DD <input type="checkbox"/> ALL		Specialty Populations Served: (Check all that apply) <input type="checkbox"/> Alzheimer/Dementia <input type="checkbox"/> AODA <input type="checkbox"/> Other: _____ <input type="checkbox"/> Autistic <input type="checkbox"/> Other: _____ <hr/> <input type="checkbox"/> Bariatric <input type="checkbox"/> Mental Health	
Program Manager: Name: _____ Email Address: _____ Telephone #: _____		County Service Provided In: Ashland (A), Barron (BA), Bayfield (BY), Burnett (BU), Douglas (D), Iron (I), Polk (PO), Price (PR), Rusk (R), Sawyer (S), Washburn(W) _____	
WI State Licensure Type & Number (if applicable submit copy with license)		WI Medicaid Provider Number (if applicable submit copy with Application)	
NPI Number (if applicable)	Residential Providers - Bed Capacity:	Other Languages Spoken (Other than English)	
Telephone Number:	Fax Number for Referrals	Hours of Operation:	

*** COMPLETE BELOW ONLY IF HAVE MULTIPLE LOCATIONS AND/OR SERVICES***

Service Provider Location Name, Address: (Street, City, State, Zip Code) (complete only if different location than above)		SPC code: _____ HIPAA code: _____	
		Service Description: : _____	
Target Populations Served: (Check all that apply) <input type="checkbox"/> Frail Elders - FE <input type="checkbox"/> Physical Disabilities - PD <input type="checkbox"/> Developmental Disabilities – DD <input type="checkbox"/> ALL		Specialty Populations Served: (Check all that apply) <input type="checkbox"/> Alzheimer/Dementia <input type="checkbox"/> AODA <input type="checkbox"/> Other: _____ <input type="checkbox"/> Autistic <input type="checkbox"/> Other: _____ <hr/> <input type="checkbox"/> Bariatric <input type="checkbox"/> Mental Health	
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