

## Provider Roster

Date Completed (M/D/Y): \_\_\_\_\_

If your organization has practitioners that require credentialing or if you are an individual solo-practice, an application and return envelope will be mailed to you from *Rural Wisconsin Health Cooperative*, iCare's contracted credentials verification organization. For the minimum Individual Provider Credentialing Criteria, please visit our [credentialing webpage](#).

	Provider First Name	Provider Last Name	Type 1 NPI	Locations Served
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				