Click to Clear Form

INDEPENDENT CARE HEALTH PLAN

Provider Affiliation Change Form

Steps for Submission:

This form is to be used when a practitioner has a change in their practice affiliation information

1. Complete the Provider Affiliation Change Form with the most current information and attach a W-9, if applicable.
2. E-mail the form to *i*Care's Provider Updates (ProviderUpdates@icarehealthplan.org) and *i*Care's Operations Department (OperationsProviderMaintenance@icarehealthplan.org) or fax the form to 414-272-5618.

Reason(s) for Submission - REQUIRED:

○ Adding Provider to Practice ○ Terminating Provider from Practice

Provider Demographics on File - REQUIRED:

Practice/Name:

National Practitioner Identifier (NPI):

Tax Identification Number (TIN):

New Practitioner Demographics:

**If you are adding or removing multiple providers, please submit an updated roster including the provider first name, provider last name, and provider Type 1 NPI.*

**iCare is required to report demographic information of providers who serve enrollees to demonstrate non-discriminatory practices. To comply with this requirement, we encourage you to provide the information below. This information is voluntary. iCare does not and shall not discriminate or base credentialing decisions on the basis of the practitioner's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.*

☐ Female ☐ Male ☐ Cultural Competency Completed

Practitioner Name: **Effective Date:**

National Practitioner Identifier (NPI):

Tax Identification Number (TIN):

Licensure: **Medicaid:** **Medicare:**

Specialty: **Accreditation:**

Board Certification:

cont'd **New Practitioner Demographics:**

Language(s):

Ethnicity:

- ○ Hispanic/Latino
- ○ Not Hispanic/Latino
- ○ Prefer not to Report

Race:

- ○ American Indian or Alaska
- ○ Native Asian
- ○ Black or African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ Prefer not to Report
- ○ Some other race
- ○ White

Practice/Corporate Address

☐ New Address ☐ Handicap Accessible ☐ Primary Location ☐ In Directory
☐ Terminated Location ☐ ADA Accessible ☐ Accepting New Patients

Street: **Suite:**

City: **State:** **Zip:**

E-Mail: **Website:**

Telephone: **Fax:** **Office Hours:**

Do you offer Telephonic Telehealth? ○ **Yes** ○ **No**

Do you offer video Telehealth? ○ **Yes** ○ **No**

Billing Address

*If your billing information has changed but you are not sure you have submitted an updated W-9, please submit one with this form

☐ New Address ☐ Electronic Billing
☐ Terminate Address

Street: **Suite:**

City: **State:** **Zip:**

E-Mail:

Telephone: **Fax:** **Office Hours:**

Contact Information

Contact Name:

Contact E-Mail:

Telephone: **Fax:**

Electronic Signature: **Date:**

Type of Contact from Contact Information (above)

Select one

Comments (please list additional affiliations if applicable):

If you prefer to complete this form manually, please submit to:

Independent Care Health Plan
Attn: Network Development
1555 N Rivercenter Dr, Suite 206
Milwaukee, WI 53212
Fax: 414-272-5618