



**Practitioner Data Sheet**



Use this form to notify Arise Health Plan and WPS Health Insurance of any practitioner changes, additions, or terminations within your organization. **Questions? Call 920-617-6325**

**Please return form to:**

ATTN: Network Development Department FAX: (920) 490-6923  
Email: [GBNetworkDevelopment Dept@AriseHealthPlan.com](mailto:GBNetworkDevelopmentDept@AriseHealthPlan.com)

**Complete sections 1, 2, and 3. Check appropriate action and complete accompanying section.**

<b>1. Contact Information</b>		<b>Today's Date</b>	
Name			
Organization			
Address			
City, State, Zip			
Telephone Number		Fax Number	
Federal Tax ID#		Email Address	

<b>2. Credentialing Contact</b>		<input type="checkbox"/> Check if same as contact info above	
Name			
Organization			
Address			
City, State, Zip			
Telephone Number		Fax Number	
Email address			

<b>3. Practitioner information</b>	
Full Name	
Professional Designation(s)	
Date of Birth	NPI #

<input type="checkbox"/>	ADD PRACTITIONER	Please complete Section A
<input type="checkbox"/>	TERM PRACTITIONER	Please complete Section B
<input type="checkbox"/>	UPDATE PRACTITIONER DEMOGRAPHICS	Please complete Section C
<input type="checkbox"/>	UPDATE PRACTITIONER PRACTICE LOCATION(S)	Please complete Section D

**SECTION A – ADD PRACTITIONER (continued on next page)**

Specialty Area of Practice		<input type="checkbox"/> Hospitalist <input type="checkbox"/> Long Term Locums (6 mo or more)	
Social Security #		License #	
DEA #		License #	
Language(s) spoken		Gender	
CAQH #		<input type="checkbox"/> None, please add to CAQH <input type="checkbox"/> None, please send paper packet	

\*Please be sure to enable CAQH access for Wisconsin Physician Services/Arise Health Plan.

**SECTION A – ADD PRACTITIONER (continued)**

Primary Practice Information		<i>Please list additional locations on a separate sheet</i>	
Clinic Name			
Address			
City, State, Zip			
Telephone Number		Fax Number	
Employment start Date			

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

**SECTION B –TERM PRACTITIONER**

Termination Date		Reason:	
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**SECTION C – UPDATE PRACTITIONER DEMOGRAPHICS**

	Was	<input type="checkbox"/> Add	<input type="checkbox"/> Change to	Eff. Date
Name				
Licensure				
Specialty				
Other				

**SECTION D – UPDATE PRACTITIONER PRACTICE LOCATION(S)**

Add this Location       Term this Location

Clinic Name			
Address			
Telephone Number		Fax Number	
Effective Date		Federal Tax ID #	

Add this Location       Term this Location

Clinic Name			
Address			
Telephone Number		Fax Number	
Effective Date		Federal Tax ID #	

For internal use only

Network Management	Arise <input type="checkbox"/>	WPS <input type="checkbox"/>	Date Sent to Cred Dept	<input type="text"/>	Initials	<input type="text"/>
Credentialing	Date app info sent	<input type="text"/>	CAQH <input type="checkbox"/>	Already Cred <input type="checkbox"/>	Initials	<input type="text"/>