|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01312 (12/2022) | | | | | | | | | | | | | | | | | |  | | | | | | | | | **STATE OF WISCONSIN** | | | |
| **IRIS PROVIDER APPLICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **INSTRUCTIONS:** | | Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. Applicants will not be considered as IRIS program service providers until all necessary paperwork is completed, submitted, and verified.  Agency Provider is defined as entities whose employees furnish the service or from which goods are purchased.  Individual Provider is defined as a person who is in an independent practice and not employed by a provider agency.  Personally identifiable information on this form is collected to verify that the application is complete and accurate, and will be used only for this purpose. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PROVIDER DEMOGRAPHICS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Organization Name  Organization Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provider’s Name (Last, First, MI)  Last, First, MI | | | | | | | | | Phone Number  Phone Number | | | | | | | | | Email Address  *May be published in Provider Directory*  Email Address | | | | | | | | | | | | |
| Title  Title | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you applying as (choose one): | | | | | | | |  | Agency Provider | | | | | | |  | Individual Provider | | | | | | | | | | | | | |
| Type of Application: | | |  | | | Initial Application | | | | | |  | | Reinstatement | | | | | | | | | | | | | | | | |
| W-9 Name (as shown on income tax return)  W-9 | | | | | | | | | | | | | | | | | | W-9 Business Name (if different from W-9 name)  Click here to enter text. | | | | | | | | | | | | |
| W-9 Exempt: | Yes | | | | No | | | | | State of Wisconsin Department of Financial Institutions ID Number: ID Number | | | | | | | | | | | | | | | | | | | | |
| **BILLING AND CLAIMS CONTACT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Check all that apply:** | | | | | | | Primary Office | | | | | | | | Mailing Address | | | | | | Billing Address | | | | | | | | | |
| National Provider Identifier (if applicable): NPI | | | | | | | | | | | | | | | | | Wisconsin Provider Management Identifier (if applicable): WPMI | | | | | | | | | | | | | |
| Tax Identification Number: EIN/SSN | | | | | | | | | | | | | | | | | Tax Qualifier: | | | | | EIN | | | SSN | | | | | |
| Organization Name  Organization Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Contact Person  Contact Person | | | | | | | | | Phone Number  Phone Number | | | | | | | | | Email Address  *May be published in Provider Directory*  Email Address | | | | | | | | | | | | |
| Fax Number  Fax Number | | | | | | | | | | | | | | | | | | Internet Address  *May be published in Provider Directory*  Web Address | | | | | | | | | | | | |
| Address  Address | | | | | | | | | City  City | | | | | | | | | State  State | | | | | | | | Zip Code  Zip Code | | | County  County | |
| **RENDERING PROVIDER CONTACT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Check all that apply:** | | | | | | | Primary Office | | | | | | | | Mailing Address | | | | | | Billing Address | | | | | | | | | |
| National Provider Identifier (if applicable): NPI | | | | | | | | | | | | | | | | | Wisconsin Provider Management Identifier (if applicable): WPMI | | | | | | | | | | | | | |
| Tax Identification Number: EIN/SSN | | | | | | | | | | | | | | | | | Tax Qualifier: | | | | | EIN | | | SSN | | | | | |
| Organization Name  Organization Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Contact Person  Contact Person | | | | | | | | | Phone Number  Phone | | | | | | | | | Email Address *May be published in Provider Directory*  Email Address | | | | | | | | | | | | |
| Fax Number  Fax Number | | | | | | | | | | | | | | | | | | Internet Address *May be published in Provider Directory*  Web Address | | | | | | | | | | | | |
| Address  Address | | | | | | | | | City  City | | | | | | | | | State  State | | | | | | | | Zip Code  Zip Code | | | County  County | |
| **DAILY OPERATIONS CONTACT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Check all that apply:** | | | | | | | Primary Office | | | | | | | | Mailing Address | | | | | | Billing Address | | | | | | | | |
| National Provider Identifier (if applicable): NPI | | | | | | | | | | | | | | | | | Wisconsin Provider Management Identifier (if applicable): WPMI | | | | | | | | | | | | |
| Tax Identification Number: EIN/SSN | | | | | | | | | | | | | | | | | Tax Qualifier: | | | | | EIN | | | SSN | | | | |
| Organization Name  Organization Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Contact Person  Contact Person | | | | | | | | | Telephone Number  Phone | | | | | | | | | Email Address  *May be published in Provider Directory*  Email Address | | | | | | | | | | | |
| Fax Number  Fax Number | | | | | | | | | | | | | | | | | | Internet Address  *May be published in Provider Directory*  Web Address | | | | | | | | | | | |
| Address  Address | | | | | | | | | City  City | | | | | | | | | State  State | | | | | | | | Zip Code  Zip Code | | | County  County |
| **SERVICES TO BE PROVIDED:** List the service(s) you wish to provide. Please reference the IRIS Service Definition Manual for a complete list of allowable services. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Services** | | | | | | | | | | | | | | | | | | | **Does this service require a license or certification?** | | | | | | | | | | |
| Services | | | | | | | | | | | | | | | | | | | License/Cert. Required? | | | | | | | | | | |
| Services | | | | | | | | | | | | | | | | | | | License/Cert. Required? | | | | | | | | | | |
| Services | | | | | | | | | | | | | | | | | | | License/Cert. Required? | | | | | | | | | | |
| **LICENSING/CERTIFICATION:** List all current licenses and certificates (if applicable). A copy of each is required with this application. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title of Licensure/Certification | | | | | Type of Licensure/Certification | | | | | | | | Licensure/Certification Number | | | | | | | State in which Licensure/Certification Obtained | | | | | | | | Expiration Date | |
| Click Here | | | | | Click Here | | | | | | | | Click Here | | | | | | | Click Here | | | | | | | | Click Here | |
| Click Here | | | | | Click Here | | | | | | | | Click Here | | | | | | | Click Here | | | | | | | | Click Here | |
| Click Here | | | | | Click Here | | | | | | | | Click Here | | | | | | | Click Here | | | | | | | | Click Here | |
| Click Here | | | | | Click Here | | | | | | | | Click Here | | | | | | | Click Here | | | | | | | | Click Here | |
| Click Here | | | | | Click Here | | | | | | | | Click Here | | | | | | | Click Here | | | | | | | | Click Here | |
| By signing below, I certify that background checks on all employees have been completed in accordance with the Wisconsin Caregiver Program.  If I am to provide specialized transportation, I certify that the vehicle used is and will be mechanically sound, has properly functioning lighting, safety, ventilation, and braking systems, and properly inflated tires without excessive wear. I further certify that proper licensing and insurance has been verified and is attached.  I understand and agree that this application will not be processed until it is deemed complete by DHS. It is my responsibility to provide a complete application. I understand and agree that the burden of producing adequate information in a timely manner and for resolving doubts is my responsibility.  I certify that the information in this document and all attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after provider approval has been awarded, may lead to suspension or termination of provider approval. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SIGNATURE –** Provider | | | | | | | | | | | | | | | | | | | | | | | Date Signed | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| Please submit this application to your Fiscal Employer Agent (FEA) using ONE of the following methods: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **AGENCY** | | | | **FAX** | | | | | | | **EMAIL** | | | | | | | | | | | | | **GROUND MAIL** | | | | | |
| GT Independence | | | | 888-972-3891 | | | | | | | [customerservice@gtindependence.com](mailto:customerservice@gtindependence.com) | | | | | | | | | | | | | 215 Broadus St.  Sturgis, MI 49091 | | | | | |
| iLIFE | | | | 414-918-4463 | | | | | | | [IRIS.Vendor@iLIFE.org](mailto:IRIS.Vendor@iLIFE.org) | | | | | | | | | | | | | 2020 W Wells St  Milwaukee, WI 53233 | | | | | |
| Outreach Health Services | | | | 877-901-5826 | | | | | | | [outreach.wi@outreachfiscalagent.com](mailto:outreach.wi@outreachfiscalagent.com) | | | | | | | | | | | | | 204 3rd Avenue, Suite 110  P.O. Box 945  Osceola, WI 54020 | | | | | |
| Premier Financial Management Services | | | | 888-302-3607 | | | | | | | [vendorpaperwork@premier-fms.com](mailto:vendorpaperwork@premier-fms.com) | | | | | | | | | | | | | 10425 W North Ave, Suite 345  Milwaukee, WI 53226 | | | | | |
| Information contained in email messages may be privileged and confidential. There is some risk that any information in an email you send may be disclosed to, or intercepted by, unauthorized third parties. By agreeing to allow the use of email as a method of communication to WI DHS, this indicates that you acknowledge and accept the possible risks associated with such communication. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |