Submit to THERESA RANDALL
FAX: 414-257-7575 / Phone: 414-257-8108

Wraparound Milwaukee Provider Network

DIRECT SERVICE PROVIDER ADD REQUEST

Entered by:_____

Date: _____

Date_____ Agency Name _____

Contact Person _____ Phone Number _____ FAX Number _____

CHECK ONE		NOTE: INCOMPLETE forms and forms that are NOT dated and signed will not be processed.						CREDENTIALS				
								CHECK ONLY IF ATTACHED				
EMPLOYEE	CONTRACT STAFF	**Provider Name** (Last Name, First Name)	**Provider D.O.B.**	CHECK IF BILINGUAL	One Service Per Line **REQUIRED** **Service Code**	Service Code and Service Name Must Match **Service Name**	**Required for AODA and Mental Health Providers** **NPI Number**	15 Hr Training Certificate	Wisc. State License	3000 Hour Letter	University/College Degree	Resume or Letter of Recommendation
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ATTACH/SUBMIT THE FOLLOWING: (background check and driver's abstract shall be dated no more than 90 days prior to this request)

(A) All three parts of the background check; (1) Background Information Disclosure Form (BID), (2) Dept. of Justice Report (DOJ), (3) Dept. of Health Services Report (DHS)

(B) Driver's license abstract

(C) Provider interest/specialty declaration form, for providers wishing to identify interests/specialties

Prepared by:_____ Date:_____

Wraparound Milwaukee Use Only: