MILWAUKEE COUNTY
DEPARTMENT OF HEALTH
& HUMAN SERVICES
BEHAVIORAL HEALTH SERVICES

BHS Medical Staff and Provider Network Practitioners
RECREDENTIALING NOTIFICATION

TIME SENSITIVE

Dear BHS Medical Staff or Provider Network Participant:

In accordance with regulatory requirements and BHS Medical Staff and Provider Network policy, all physicians, licensed psychologists, advanced practice nurses and physician assistants must be recredentialed at least every thirty-six months. Therefore, it is essential that you submit the Recredentialing Application fully completed along with all required supporting documentation, at this time.

Failure to make timely reapplication or to submit a complete application including supporting documents may result in lapse in your approval to provide services. Practitioners are encouraged to submit the completed Recredentialing Application and supporting documentation **90 DAYS PRIOR TO YOUR CURRENT CREDENTIALING APPROVAL EXPIRATION.**

If you have any questions regarding recredentialing, please refer to the **BHS Medical Staff and Provider Network Credentialing Program** located in ***PolicyStat*** and the BHS Providers (milwaukee.gov) website, if copy is not enclosed or contact a member of the BHS Medical Staff Services team by phone or email.

Sincerely,

Jodi Mapp
Jodi Mapp, Manager of Medical Staff Services
BHS Medical Staff Services

Kiara Abram
Kiara Abram, Medical Staff Coordinator
BHS Medical Staff Services

Enclosure(s)

Instructions for Completing
Recredentialing Application - BHS Medical Staff and Provider Network

To effectively use the Application, the following is suggested:

- Type or legibly complete the Application in BLACK or BLUE ink.
- All information on the **Application must be complete and accurate**. **DO NOT LEAVE ANYTHING BLANK.** If a section of the Application does not apply to you, **be sure to check the box or write N/A or NONE, in the first box of that Section**. **An incomplete Application will delay processing and result in delay of approval decision. BE SURE TO RETURN ALL PAGES.**
- **Hospital and ASC Affiliations, Faculty/Clinical Teaching Appointments and Practice Affiliations (pages 3-5)** Copy page(s) to report additional affiliations, if needed, or include a separate list with all required information. Include all current affiliations or affiliations previously held that have lapsed within the last three (3) years. Be sure to include Credentialing Office/Program Director contact phone #, fax# and email. **Include start/end dates (MM/YYYY), where applicable.**
- **Signature and current date are required on the "Disclosure Questions" form AND Practitioner Health Status Attestation.** For any new **Yes** responses since previous credentialing application submission, provide detailed information/explanation on a separate page and attach. Be sure to sign and date the attachment(s).
- If updates or changes need to be made to the completed Application, use a black or blue pen to strikeout information and write in modification. **All changes must be initialed and dated**.
- **Telemedicine practitioners** – be sure to include the office/practice location(s) from where you are physically located when performing telemedicine services under Offices on p.1. Include the associated BHS and/or Provider Network practice affiliation on page 5.
- **Before returning Application, be sure to SIGN & DATE where required and ATTACH the following, as applicable:**
  - ❒ Signed and dated ***Consent, Authorization, Release and Attestation***
  - ❒ Signed and dated ***Practitioner Health Status Attestation***
  - ❒ Signed and dated ***Disclosure Questions***
  - ❒ Signed and dated ***Explanation Statement*** for any change(s), from previous application (Q. 2-18)
  - ❒ Signed and dated ***Practitioner Health Status Attestation Explanation Statement*** if "**Yes**" to any Questions
  - ❒ ***CME/CE Documentation*** for the last (3) three years (certificates or tracking print-out preferred)
  - ❒ Current copy of ***Drug Enforcement Administration (DEA) Registration***
  - ❒ Signed and dated ***Private Practice Statement*** *(required for BHS Medical Staff only, See Policy)*
  - ❒ Current ***Malpractice Policy Facesheet/Certificate of Insurance*** (required for all Provider Network practitioners)
  - ❒ Completed ***Wisconsin Caregiver Background Information Disclosure (BID) Form***.
    Use Department of Health Services, Division of Quality Assurance Form F-82064 (01/2022). Applicants that do not reside in Wisconsin and/or work within a state(s) other than Wisconsin will also be subject to out-of-state background checks. List current/primary practice (business) address on page one of the BID form. In Section B, if Yes, to questions 4 and/or 6, please be sure to provide required detail in that section(s), i.e., agency name(s), dates, etc.

Advanced Practice Nurses & Physician Assistants

- ❒ Documentation of current ***Physician Collaboration Arrangement.*** Must be signed and dated by both the applicant and the physician (BHS physician collaborator or participating network physician collaborator, as applicable, must be trained, educated and experienced to deliver health care services within the scope of the patient population to be served by the APNP/PA, i.e., psychiatry/child psychiatry, addiction medicine). For recredentialing, there must be evidence that the collaboration arrangement has been recently reviewed (dated within 90 days of submission) by both parties and updated, if applicable.
  - ❒ Physician Assistants - in lieu of a collaboration agreement arrangement may submit a current statement signed by a participating network physician confirming that the PA is under the direction and practice management of the participating physician
- ❒ Copy of current NP/CNS/PA ***Specialty Certification***, if renewed within last three years or since last credentialing approval

Provider Network Participants Only:
Practitioner's Network Agency(s) shall be required to submit the required background check results and DHS waiver, if applicable, to BHS Medical Staff Services at time of initial credentialing and when making application for recredentialing. Completed BID form, DHS Caregiver and DOJ results are all required and must be dated within 90 days of the credentialing decision.

- ❒ **Addendum 1:** Primary Office Location Clinic Hours: Complete form in entirety including after-hours coverage arrangements.
- ❒ **Addendum 2:** List ALL services you are requesting to provide – include code and service description
- ❒ **APNPs requesting CSP participation:** Copy of approved DHS 63 Waiver/Variance to Use the APNP applicant in the Community Support Program(s). If Agency has multiple CSP locations under different license #s, a waiver for each CSP license where the APNP will be used is required.

Completed application and all required supporting documents must be received by the specified due date.

Send by Mail to: **Behavioral Health Services**
Attn: Medical Staff Services
1230 W. Cherry Street, 3rd Floor
Milwaukee, WI 53205-2117

by E-Mail to: **BHDCredentialing@milwaukeecountywi.gov**
by FAX to: **(414) 289-8567**

Rev. 5-2026

Milwaukee County Behavioral Health Services
RECREDENTIALING APPLICATION

Check All Applicable: ☐ **BHS Medical Staff –** Current Employee/Contractor with BHS–Adult Community Services, Youth & Child Services, Mobile Crisis Services and/or Other BHS Department or Program

☐ **CARS Provider Network -** Community Access to Recovery Services (includes Adult & Youth CCS)

INSTRUCTIONS: Applicant must fill out the application in its entirety and provide all required supporting documentation in accordance with the instructions provided. Failure to do so will result in the return of the application to the applicant and will delay processing.

PERSONAL INFORMATION

Last Name	First Name	Middle Name or Middle Initial
Other Names By Which You Have Been Known (including maiden name)		Degree
Home Street Address	Home City/State/Zip	Gender ☐ Male ☐ Female
Home Phone Number (Include Area Code)	Cell Phone Number (Include Area Code)	
Preferred E-Mail Address for professional correspondence	Citizenship	If not a US Citizen, specify status & Visa #

OFFICES: List current BHS &/or Network office site(s). Identify site as primary, secondary &/or mailing & billing address.

List current or recent Non-BHS Provider Network practice sites on page 5 only.

Office #1

Office Name	Check all applicable boxes: ☐ Primary Office ☐ Secondary Office ☐ Mailing Address ☐ Billing Address
Office Street Address	
Office City, State and Zip Code	Start and End Dates (Month & Year)
Office Phone 1 (Include Area Code) / Office Phone 2 (Include Area Code)	Office Fax (Include Area Code)

Office #2

Office Name	Check all applicable boxes: ☐ Primary Office ☐ Secondary Office ☐ Mailing Address ☐ Billing Address
Office Street Address	
Office City, State and Zip Code	Start and End Dates (Month & Year)
Office Phone 1 (Include Area Code) / Office Phone 2 (Include Area Code)	Fax (Include Area Code)

Office #3

Office Name	Check all applicable boxes: ☐ Primary Office ☐ Secondary Office ☐ Mailing Address ☐ Billing Address
Office Street Address	
Office City, State and Zip Code	Start and End Dates (Month & Year)
Office Phone 1 (Include Area Code) / Office Phone 2 (Include Area Code)	Office Fax (Include Area Code)

Accepting New Patients:	☐ Yes	☐ No

Languages You Speak Other than English

SPECIALTIES

ALL APPLICANTS—List your primary practice specialty and Board/Certification Status. List any additional Specialties, in which you have trained, if applicable)

Specialty (AODA, Psychiatry, Child Psychiatry, Internal Medicine, Psychology, Psych/MH, Family Practice, etc.)	*Primary*	*Secondary*	*Board Certified (Yes or No)*		*Name of Board (if applicable) (i.e., ABPN, AOA, ANCC, ABPP)*	*Year Certified*	*Last Re-Certified*	*Expiration Date or State if Contingent on MOC*
	☐	☐	☐	☐				
	☐	☐	☐	☐				
	☐	☐	☐	☐				
	☐	☐	☐	☐				

ID NUMBERS

State License: ***List all CURRENT professional licenses. If more than 5, attach list of additional licenses held.***

Type of Wisconsin License (or Indicate if Other State)	***License Number***	***Expiration Date***

Other ID Numbers

Type of Number	***Number*** (If none or not applicable, please indicate.)	***Expiration Date (where applicable)***
DEA Number		
Medicare Provider Number		**Subject to Revalidation**
Medicaid Provider Number		**Subject to Revalidation**
National Provider Identifier Number		**N/A**

HOSPITAL & AMBULATORY SURGERY CENTER (ASC) AFFILIATIONS

Recredentialing: ***List all hospitals and ASC's where you have had an affiliation, at anytime, in the past three (3) years.*** *Indicate affiliation status (Active, Courtesy, Provisional, Temporary, etc.) Begin with current affiliations. If reporting more than five (5), first copy this page and attach it to the application.*

Report Non-hospital PRACTICE AFFILIATIONS on page 5. Do NOT include Residency or Internship information in this area.

☐ **Check box if NONE**

Name of Hospital/ASC			Start and End Dates (Month & Year)
Street Address			City, State and Zip Code
List Medical Staff Office or Credentialing Contact Information Below			
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Email Address	Affiliation Status

Name of Hospital/ASC			Start and End Dates (Month & Year)
Street Address			City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Email Address	Affiliation Status

Name of Hospital/ASC			Start and End Dates (Month & Year)
Street Address			City, State and Zip Code
List Medical Staff Office or Credentialing Contact Information Below			
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Email Address	Affiliation Status

Name of Hospital/ASC			Start and End Dates (Month & Year)
Street Address			City, State and Zip Code
List Medical Staff Office or Credentialing Contact Information Below			
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Email Address	Affiliation Status

Name of Hospital/ASC			Start and End Dates (Month & Year)
Street Address			City, State and Zip Code
List Medical Staff Office or Credentialing Contact Information Below			
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Email Address	Affiliation Status

EDUCATION AND TRAINING

(Include only information if something has changed from previous credentialing approval, i.e., completed, changed or started residency program, fellowship, preceptorship, etc.)

☐ **Check box if *No Changes in last 3 years***

Medical Education or Professional School

Residency

Name of Institution		**Program**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Program E-Mail Address	Program Director	

Fellowship

Name of Institution		**Program**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Program E-Mail Address	Program Director	

Other Formal Training, such as Preceptorships, etc.:

Name of Institution		**Type of Program**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Program E-Mail Address	Program Director	

FACULTY OR CLINICAL TEACHING APPOINTMENTS: *List all current appointments.*

☐ **Check box if NONE**

Name of Institution		**Faculty Rank**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Program Phone Number (Include Area Code)	Fax Number (Include Area Code)	Program E-Mail Address	Program Director	

Name of Institution		**Faculty Rank**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Program Phone Number (Include Area Code)	Fax Number (Include Area Code)	Program Director E-Mail Address	Program Director	

PRACTICE AFFILIATIONS: ***List all current practice affiliations or any held within the past three (3) years beginning with current BHS Practice Site and/or Provider Network affiliation(s).*** *If reporting more than seven (7), first copy this page and attach or include a list with same information.* ***Report HOSPITAL affiliations on page 3.***

REQUIRED FOR ALL APPLICANTS

Name of Facility/Agency ☐BHS ☐Network ☐Non-Network		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Agency Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	
Name of Facility/Agency ☐BHS ☐Network ☐Non-Network		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Agency Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	
Name of Facility/Agency ☐BHS ☐Network ☐Non-Network		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Agency Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	
Name of Facility/Agency ☐BHS ☐Network ☐Non-Network		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Agency Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	
Name of Facility/Agency ☐BHS ☐Network ☐Non-Network		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Agency Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	
Name of Facility/Agency ☐BHS ☐Network ☐Non-Network		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Agency Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	
Name of Facility/Agency ☐BHS ☐Network ☐Non-Network		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Agency Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	

EXPLANATION OF ABSENCE FROM PRACTICE: *Have you had any gaps or absence from practice within the last 24 months that exceed one (1) year, i.e., an extended medical or personal leave of absence, military leave, retired but then returned to practice, etc. Please explain any such gaps in the space provided below.* ***Attach a separate explanation statement if more space is required and indicate "see attached."***

☐ **Check box if no gaps or absences to report. Proceed to next section.**

From Date	To Date	Explanation of Absence From Practice

PROFESSIONAL LIABILITY INSURANCE

Enter CURRENT Professional Liability Insurance Coverage Below.
Identify Who Maintains Professional Liability Coverage on Your Behalf:

ATTACH Copy(s) of Current Certificate(s) of Insurance for Individual/Personal or Non-County Employer Coverage*

Current Liability Carrier ☐ **Milwaukee County (Employee)** ☐ **Individual/Personal Coverage*** ☐ **Employer Coverage (Non-County)***

Name of Company		Start Date (Month & Year)	
Complete Address		Policy Number	
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address	Coverage Amounts

Other or Previous Liability Carriers (List all carriers for past 3 years)

Name of Company ☐ **Individual/Personal Coverage** ☐ **Employer Coverage**		Start & Finish Dates (Month & Year)	
Complete Address		Policy Number	
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address	Coverage Amounts

Name of Company ☐ **Individual/Personal Coverage** ☐ **Employer Coverage**		Start & Finish Dates (Month & Year)	
Complete Address		Policy Number	
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address	Coverage Amounts

PRACTITIONER HEALTH STATUS ATTESTATION *(ALL APPLICANTS)*

1.	Are you in anyway limited in your ability to perform the essential functions of the practice of your medical/clinical specialty with reasonable skill and safety?	☐ Yes ☐ No
2.	Are you currently engaged in the illegal use of drugs? Currently means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine or other licensed clinical profession. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. Illegal use of drugs refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. 812.22. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the controlled Substances Act or other provision of Federal law. The term does include, however, the unlawful use of prescription-controlled substances.	☐ Yes ☐ No

If you answered "**Yes**" to either of the above, please give a full explanation of the details on a **SEPARATE PAGE AND ATTACH** it to this application. Please be sure to **sign and date the explanation**.

Name-Print Above **Practitioner Signature** **Date**

APPLICANT SIGNATURE IS REQUIRED – STAMPED, TYPED OR PROXY SIGNATURES ARE NOT ACCEPTABLE

DISCLOSURE QUESTIONS

If you answer "YES" to questions numbered 2 through 18, please provide details on a SEPARATE PAGE, SIGN, DATE AND ATTACH, if not previously explained or has changed.* Include a copy of any order or settlement where applicable.

1.	Have there ever been, or are there currently, any professional or work-related claims, settlements or judgments against you, you & your employer and/or other third party, even if not resulting in monetary damages, or have you received any notice of "Intent to File" or a "request for mediation"? **IF YOU ANSWER "YES," PLEASE PROVIDE DETAILED INFORMATION ON THE ENCLOSED PROFESSIONAL LIABILITY ACTION EXPLANATION FORM.**	☐Yes ☐No
2.	Have you ever had any professional liability insurance coverage voluntarily or involuntarily canceled, declined or modified (i.e., reduced limits, restricted coverage), or has any renewal ever been refused, or have you voluntarily given up coverage?	☐Yes ☐No
3.	Have you ever been denied, or have you voluntarily or involuntarily given up, membership, or renewal of membership, or been subject to any disciplinary action in any hospital, IPA, HMO, PHO, PPO, managed care organization or professional society, or is any such action pending?	☐Yes ☐No
4.	Have your clinical privileges or employment at any hospital or healthcare institution been voluntarily or involuntarily limited, suspended, revoked, not renewed, or subject to probationary or other disciplinary conditions, or have proceedings toward any of those ends been instituted or recommended by a hospital administration, medical staff or committee or governing board?	☐Yes ☐No
5.	Has your request for any specific clinical privileges been voluntarily or involuntarily denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a medical staff or committee or governing board?	☐Yes ☐No
6.	Have you ever had any previous or pending challenges to, or voluntarily or involuntarily relinquished any medical staff membership, clinical privilege(s), professional license(s), or narcotics registration as the result of any investigation or disciplinary action?	☐Yes ☐No
7.	Have you ever been disciplined by any State Board of Medical Examiners, or by any Professional Conduct Board, or have you ever been reprimanded, or fined by any state or federal agency that disciplines physicians or allied health professionals?	☐Yes ☐No
8.	Have you ever been reprimanded, censured, excluded, suspended or disqualified by Medicare, Medicaid, CLIA or any other health plan for which you provide services?	☐Yes ☐No
9.	Have you ever received notice of a proposed or actual exclusion from any health care program funded in whole or part by the federal government or any state health care program, including Medicare or Medicaid?	☐Yes ☐No
10.	Has your Drug Enforcement Agency or other controlled substances authorization ever been voluntarily or involuntarily denied, revoked, suspended, reduced or not renewed, or have proceedings toward any of those ends been instituted?	☐Yes ☐No
11.	Has your specialty board certification or eligibility ever been voluntarily or involuntarily denied, revoked, relinquished, not renewed, suspended, reduced, or have any proceedings toward any of those ends been instituted?	☐Yes ☐No
12.	Has your authorization to practice in any jurisdiction (state or county) ever been voluntarily or involuntarily revoked, suspended, or subject to probation or any conditions or limitations?	☐Yes ☐No
13.	Have you ever been convicted of, or pleaded guilty or no contest to, a felony, serious or gross misdemeanor, or any crime or municipal violation, involving dishonesty, assault or sexual misconduct or abuse, or abuse of controlled substances or alcohol, or are charges pending against you for any such crimes by information, indictment or otherwise?	☐Yes ☐No
14.	To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB)?	☐Yes ☐No
15.	Will practicing to the fullest extent of your licensure, qualifications, and privileges, with or without reasonable accommodation, in any way pose a risk of harm to your patients?	☐Yes ☐No
16.	In the past five years, up to, and including the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	☐Yes ☐No
17.	Have you ever been court-martialed, investigated, sanctioned, reprimanded or cautioned by a hospital or other healthcare facility of any military agency, been involuntarily terminated or forced to resign, or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility of any military agency?	☐Yes ☐No
18.	If you perform clinical research, have you ever had any clinical research study terminated involuntarily, been asked to terminate a clinical research study before it was completed or had any other discipline or sanctions with respect to your clinical research?	☐Yes ☐No
19.	Is your professional liability insurance current? (If No, please explain)	☐Yes ☐No ☐in residency/ fellowship
20.	Do your professional liability insurance amounts meet state minimum requirements? (If No, please explain)	☐Yes ☐No ☐in residency/ fellowship

If you answered "Yes" to any of Questions 2-18, required details/explanation ☒ attached OR was ☐ previously reported and already on file.*
Please be sure to sign and date any included attachment(s).

I understand and agree that the burden of producing adequate information in a timely manner and for resolving doubts is my responsibility. I understand and agree that the application will not be processed until the application is deemed complete by the healthcare organization. It is my responsibility to provide a "complete" application.

I certify that the information in this document and any attached document(s) is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after staff membership/privileges or network participation has been awarded to me, may lead to suspension or termination of that membership/privileges and/or participation.

Name-Print Above **Practitioner Signature** **Date**

APPLICANT SIGNATURE IS REQUIRED – STAMPED, TYPED OR PROXY SIGNATURES ARE NOT ACCEPTABLE

Professional Liability Action Explanation Form (ALL APPLICANTS)

This form **must be completed if you answered "yes" to question #1** on the Disclosure Questions. If reporting more than one incident, copy this page and **COMPLETE A SEPARATE FORM for EACH matter**.

Please complete this form if there have ever been, or is currently, any professional or work-related claims, settlements or judgments against you, your employer, or third party, even if not resulting in monetary damages or if you have received any notice of "Intent to File". If you have had more than one claim, please photocopy this page prior to completing. In order to maintain HIPAA compliance please remove all patient identifiers (i.e., name, DOB) from submitted documents.

P l e a s e P r i n t

Date of Alleged Incident	Date Suit Filed
Docket Number	**Hospital/City/State of Incident**

Your Relationship to Patient (Admitting/Attending/Treating Practitioner, Consultant, etc.)

Allegation

Liability Carrier when Incident Occurred

Additional Named Defendant(s)
☐ Yes ☐ No

Claim Status

☐ ***OPEN*** *– If open, amount being sought:* ***$***	☐ ***CLOSED*** *– If closed, indicate method of closing* ☐ ***Dismissal*** ☐ ***Settlement*** ☐ ***Judgment***	***Amount of settlement or judgment:*** ***$***

Case Description: - *Please print.* **If additional space is necessary, attach adequate clinical detail to allow proper evaluation by a committee of physicians.**

1) Summarize the circumstances giving rise to the action. If the action involves patient care, describe a narrative that provides your care and treatment of the patient. If additional space is necessary, attach adequate clinical detail to allow proper evaluation by a committee of physicians.

2) Condition And Diagnosis At Time Of Incident

3) Dates And Description Of Treatment Rendered

4) Condition Of Patient Subsequent To Treatment

Application Approval: Approved by action of the BHS Medical Staff and Provider Network Credentialing Committee, 11-21-2019; 6-16-2026 Service Code Section added 11-23-2019 Revision approved: 5-20-2021; 10-11-2022; 09-19-2023; 6-16-2026

Applicant Consent, Authorizations, Release from Liability and Attestation Form

In making application for credentialing, recredentialing and/or network participation with the ***MILWAUKEE COUNTY BEHAVIORAL HEALTH SERVICES (BHS) MEDICAL STAFF and/or PROVIDER NETWORK-CARS***, I accept the terms and conditions set forth below and intend to be legally bound by them, regardless of whether my credentialing request is approved. The following conditions and terms shall remain in effect for any period of credentialing for which I may be approved. I hereby signify my willingness to make myself available for interviews and/or to answer any questions in regard to my application.

Authorization to Obtain Information

I hereby authorize BHS, its Medical Staff, the Provider Network (CARS &/or Wraparound) and/or their representatives to consult with, request and obtain information, including, but not limited to, federal, state and county level criminal and civil history records and all information acquired in connection with the review and evaluation of health care services, from associates, representatives and members of hospital medical staffs, medical groups/practices and provider networks with which I have been associated, representatives of educational facilities, professional certification boards, professional associations, state and federal regulatory and licensing departments, professional liability insurance carriers and any other organizations or individuals who may have information bearing on my professional competence, character, ethical qualifications, credentials, training, experience, mental and physical health status, past and present malpractice coverage and claims, ability to work cooperatively with others, and any other matter having bearing on my request for credentialing or recredentialing. I specifically authorize and direct these organizations and individuals to release to BHS and to consult with BHS regarding any and all information which they may possess that may be material to an evaluation of my professional performance, qualifications and competence. I further explicitly authorize Milwaukee County Behavioral Health Services, its Medical Staff, its Provider Network and/or their representatives to conduct and/or obtain any and all Caregiver, criminal and/or other required background checks, in connection with this application.

Release from Liability

To the fullest extent permitted by law, I hereby extend absolute immunity to and release from any and all liability, BHS and all representatives of BHS, the Medical Staff and the Provider Network for their acts performed and statements made in connection with evaluating my application, credentials and qualifications. To the fullest extent permitted by law, I also hereby extend absolute immunity to and release from any and all liability, any and all individuals, healthcare entities, organizations, agencies and their representatives who provide information to any representative of BHS concerning my professional competence, ethics, character or other qualifications for credentialing and medical staff and/or network participation, and I hereby consent to the release of such information to BHS.

Burden of Providing Accurate and Complete Information

I understand and agree that I, as an applicant for credentialing and medical staff and/or network participation, have the burden of producing adequate information for proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications. I agree and acknowledge that it is my obligation to provide adequate information to process my application, and that my application will not be processed until it is deemed complete by BHS. I further understand that any significant misrepresentation, misstatements in, or omissions from, this application, whether intentional or not, may constitute cause for the immediate cessation of the processing of my application, denial of credentialing or cause for termination from BHS medical staff and/or network participation in the event that credentialing approval had been granted prior to the discovery of such misrepresentation, misstatement or omission. All information submitted by me in this application or attached to this application is true, accurate and complete to the best of my knowledge and belief.

Affirmation to Comply with the BHS Medical Staff and Provider Network Credentialing Program, Governing Document(s) and Policies

In making this application for credentialing and BHS medical staff and/or network participation, I acknowledge that I have received, or been given access to, and read the *BHS Medical Staff and Provider Network Credentialing Program and Governing Document*, the medical staff rules and regulations and medical staff and provider network policies and procedures, as applicable to my participation request. I agree to be bound by the terms of the Credentialing Program and all applicable Governing Document(s), rules, regulations and policies and procedures as may from time to time be enacted, including any amendments thereto, if my credentialing request is approved and, in all matters, relating to the consideration of my application for credentialing and participation on the BHS medical staff and/or in the provider network. I further specifically acknowledge and accept the provisions of said *BHS Medical Staff and Provider Network Credentialing Program and Governing Document* relating to confidentiality, credentialing and the continuation of medical staff and/or network participation, if approved.

I understand that my request for credentialing or recredentialing will be evaluated in accordance with the procedures defined in the *BHS Medical Staff and Provider Network Credentialing Program* and that all recommendations relative to my application are subject to ultimate action and approval of the BHS Credentialing Committee.

I agree that the practitioner credentialing/recredentialing appeals process set forth in the *BHS Medical Staff and Provider Network Credentialing Program and Governing Document* shall be my sole and exclusive remedy with respect to recommendations for approval, denial, termination, or restriction of participation.

I agree to provide updated information regarding all questions on the application form as new information becomes available during the application process and throughout my medical staff and/or network affiliation, if approved. I also agree to provide additional information, as requested. If approved, I agree to keep the BHS Credentialing Committee informed of any updates or changes to the information contained in the application, including but not limited to, (1) any investigations by a state licensure agency; (2) any voluntary or involuntary termination of Medical Staff/Professional Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges or participation at any facility; (3) the filing of any professional liability lawsuit against me; (4) any arrest, indictment or pending charges or conviction to a felony, serious gross misdemeanor, any crime or municipal violation involving dishonesty, assault, sexual misconduct or abuse or abuse of controlled substances or alcohol; (5) any change in my eligibility for participation in the Medicare or Medicaid programs; or (6) any change in my ability to safely and competently practice my profession because of health status issues, including impairment, throughout the period of my BHS Medical Staff employment and/or network participation.

Use of Photocopy, Facsimile, Scan

I agree that a photocopy, facsimile or scan of this document with my signature may be accepted by any organization or individual from which the above referenced information is requested, with the same authority as the original, and that **this document shall remain valid for two (2) years from the date of signature.**

_____ _____

DATE-MM/DD/YYYY SIGNATURE

PRINTED NAME: _____

The BHS Credentialing Committee, Medical Staff Services, the Medical Staff and Provider Network will treat this application and any information secured in connection therewith in confidence except as is necessary for accomplishing the credentialing approval process, in accordance with the *BHS Medical Staff and Provider Network Credentialing Program*, policies and procedures, and state and federal laws governing confidentiality of information acquired in connection with the review and evaluation of a healthcare provider.

Rev. 5/2026

ADDENDUM 1
Milwaukee County Behavioral Health Services
PROVIDER NETWORK PRACTITONERS - RECREDENTIALING

Practitioner Name:	Date:

After Hours Coverage: Please complete the attached regarding your office availability and after hours coverage arrangements.

Primary Office Location (Network Agency):

Clinic Hours			**Practitioner Specific Hours**		
	AM	PM		AM	PM
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		

Name(s) of Partners/Associates: _____
Practitioner(s) who share call who are not part of your practice group: _____
Name and Professional Status: _____
Address: _____

Secondary Office Location (Network Agency):

Clinic Hours			**Practitioner Specific Hours**		
	AM	PM		AM	PM
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		

Name(s) of Partners/Associates: _____
Practitioner(s) who share call who are not part of your practice group: _____
Name and Professional Status: _____
Address: _____

****COVERAGE ARRANGEMENTS:** Please provide detailed after hours coverage for each of your affiliate agencies, to include coverage when you are on vacation and days you are not located at/working for an applicable network agency.

_____
_____
_____

CHECK ALL APPLICABLE COVERAGE ARRANGEMENTS FOR AFTER HOURS AND ABSENCES

- ☐ Answering Service and Page
- ☐ On-call Physician via Answering Service
- ☐ On-call Physician via Answering Machine/Recorded Message
- ☐ Answering machine
- ☐ Refer to ER
- ☐ Other: _____

If more than two (2) network affiliations, copy page before completing and list additional location information and attach to application.

ADDENDUM 2
Milwaukee County Behavioral Health Services
PROVIDER NETWORK PRACTITIONERS - RECREDENTIALING

Practitioner Name:	Date:

***SERVICES:* List All Services You Are Requesting To Provide**

REQUIRED for all PROVIDER NETWORK Services. NOT applicable for BHS Medical Staff Services.

USER PROGRAM(S): ☐CBRF ☐CCS ☐CSP ☐DAY TX-AODA ☐DETOX ☐MAT ☐OUTPT-AODA ☐OUTPT-MH ☐OTHER: ____

SERVICE CODE (If known)	***SERVICE NAME/TYPE OF SERVICE*** *(Attach Separate List if Additional and Check Box – See Attached* ☐*)*

PROVIDER NETWORK ADVANCED PRACTICE NURSE PRESCRIBERS AND PHYSICIAN ASSISTANTS	
List Physician Collaborator(s) (Name and Specialty)	
Enclose copy of current ***Physician Collaboration Arrangement.*** In lieu of a collaboration agreement arrangement, PAs may submit a current statement signed by a participating network physician confirming that the PA is under the direction and practice management of the participating physician.	

FOR BHS MEDICAL STAFF SERVICES USE ONLY	
Credentialing Approval ☐ by Chair ☐ by Committee	**Date:**
Any Exceptions Noted: ☐ NO ☐ YES (as listed below)	