MILWAUKEE COUNTY
DEPARTMENT OF HEALTH
& HUMAN SERVICES
BEHAVIORAL HEALTH SERVICES

BHS Medical Staff and Provider Network Practitioners
REQUEST TO AMEND CURRENT PARTICIPATION

Dear BHS Medical Staff Employee or Provider Network Practitioner:

In connection with your request or your agency's request to amend your current participation, please complete the **Request to Amend Current Participation** application.

In order to process a credentialing amendment request, you must be a current BHS medical staff employee/contractor or currently credentialed and participating within the network with one or more provider agencies. To ensure timely processing of your participation change(s), please review your application for accuracy and completeness prior to submission. Once your request to amend your current participation has been reviewed and recommended for approval, you will be notified, in writing, that you may begin accepting referrals and providing the new participant services.

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

Sincerely,

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

Kiara Abram, Medical Staff Coordinator
BHS Medical Staff Services

Enclosure(s)

INSTRUCTIONS FOR COMPLETING
BHS MEDICAL STAFF & PROVIDER NETWORK PRACTITIONER CREDENTIALING
REQUEST TO AMEND CURRENT PARTICIPATION

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**. An incomplete Application will delay processing**. BE SURE TO RETURN ALL PAGES AND SUPPORTING DOCUMENTS.**
- **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.**

Requirements for amending current participation are listed below.

1. BHS/Network Agency Offices – include complete address, phone/fax numbers, start date.
2. Be sure to list Practice Specialty(s) and Certifying Boards with dates, as applicable.
3. Additional education/training completed since last credentialing approval, if applicable.
4. Certification and Attestation signatures are required.
5. If the new services you are requesting include special populations *(i.e., children, DD population, etc.)* or treatment modalities, recent CME/CE and/or case logs should be provided unless training/Board Certification in that practice area was attained within the last 24 months.
6. If ADDING or CHANGING your Provider Agency Affiliation(s), include information on page 1 under "Offices" and list START DATE or PENDING if start date is not yet known. If you have separated from any Provider Network Agencies, please list Agency and include END DATE or anticipated end date, if pending.
    a. When adding a new Agency Affiliation, a newly completed Wisconsin Caregiver Background Information Disclosure (BID) form, DHS Caregiver Background Check and Department of Justice criminal background check by the new agency shall be required. BID form, DHS letter and DOJ report submissions by agency must be dated within 90 days of the credentialing decision.
7. Provide a current Certificate of Insurance for the current and if applicable new Provider Agency affiliation(s).

Additional Requirements for Allied Health:

1. **APNPs and PAs**: Documentation of current physician collaboration or supervision arrangement, specific to this amendment request. 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). 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.
2. **APNPs**: Copy of current **Specialty Certification** from the American Nurses Credentialing Center *(or equivalent national accreditor, as deemed acceptable by the BHS Credentialing Committee), ONLY if there has been a change(s) or recertification occurred since most recent credentialing approval*
3. **Physician Assistants**: Copy of Certification by the National Commission on Certification of Physician Assistants*, ONLY if there has been a change(s) or recertification occurred since most recent credentialing approval*
4. **Psychologists**: If requesting clinical child psychology services for the first time, applicant must be able to demonstrate the provision of inpatient, outpatient, or consultative services, reflective of the scope of services being requested, for at least 10 child and/or adolescent patients during the past 24 months *(provide patient logs)*; OR demonstrate successful completion of child and adolescent experience during a recognized clinical internship, clinical fellowship, or research in a clinical setting within the past 24 months OR current participation in a maintenance of certification program through the American Board of Professional Psychology.

Submit completed application and all required supporting documents as follows:

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**

Milwaukee County Behavioral Health Services
BHS MEDICAL STAFF & PROVIDER NETWORK PRACTITIONER CREDENTIALING
REQUEST TO AMEND CURRENT PARTICIPATION

Current Participation:
- ☐ **BHS Medical Staff**
- ☐ **CARS-Community Access to Recovery Services Network (Includes Adult & Youth CCS)**

Change(s) Requested:
- ☐ **ADD BHS Medical Staff Services** ***(Employment Offer or Professional Services Agreement to work within a BHS Service/Program Required)***
- ☐ **ADD CARS-Community Access to Recovery Services (Includes Adult & Youth CCS)**
- ☐ **ADD New/Additional Services/User Program(s) Under Current Network Participation Approval**
- ☐ **ADD or CHANGE a Provider Agency Affiliation(s)**

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. Copy pages and attach if reporting more offices, specialties, services or education than the space allotted.

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		

OFFICES: List BHS &/or Provider Network practice sites. Identify a primary, mailing and billing address.

Office #1 ☐**CURRENT**-BHS/Network Agency Affiliation (No Change) ☐**ADD**-BHS/Network Agency Affiliation ☐**REMOVE**-BHS/Network Agency Affiliation-No longer Affiliated

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 ☐**CURRENT**-BHS/Network Agency Affiliation (No Change) ☐**ADD**-BHS/Network Agency Affiliation ☐**REMOVE**-BHS/Network Agency Affiliation-No longer Affiliated

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 ☐**CURRENT**-BHS/Network Agency Affiliation (No Change) ☐**ADD**-BHS/Network Agency Affiliation ☐**REMOVE**-BHS/Network Agency Affiliation-No longer Affiliated

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)

SPECIALTIES *ALL APPLICANTS—List your primary practice specialty and Board/Certification Status. List any sub-specialties, in which you have trained, if applicable, to this request*

Specialty	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
	☐	☐	☐	☐				
	☐	☐	☐	☐				
	☐	☐	☐	☐				

SERVICES: List All NEW Services You Are Requesting To Provide *(NETWORK APPLICANTS ONLY)*

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 ☐)* ☐ Section N/A

EDUCATION AND TRAINING

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

☐ Check box if *NO CHANGES since most recent credentialing approval*

Medical / Professional Education – Residency, Fellowship, Other Formal Training Program

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	

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	

APPLICANT CERTIFICATION

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 there have been NO CHANGES or matters requiring disclosure and/or explanation, since my most recent credentialing approval by the BHS Credentialing Committee OR if there was a change, the matter was disclosed and explained to the satisfaction of the Committee.

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

Dev. 6-23-2021; Rev. 1-2023, 7-2023; 9-2023, 5-2026
Application Approval: Approved by action of the Credentialing Committee, 12-16-2021; 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) 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* 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) 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
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.