Milwaukee County Behavioral Health Division
PROVIDER NETWORK - RECREDENTIALING

9455 WATERTOWN PLANK ROAD, MILWAUKEE, WI 53226

Dear BHD Provider Network Practitioner:

In accordance with regulatory requirements and BHD Provider Network policy, all physicians, licensed psychologists and advanced practice nurses 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.

Requirements for re-credentialing submissions are listed below. **Please ensure that you check "NONE or NOT APPLICABLE," when appropriate under each header section**. Do not leave any sections blank.

1. The Recredentialing Application needs to be filled out completely with current dated signatures.
2. Offices – need address, phone, start and end dates and office contact.
3. Be sure to list Practice Specialty(s) and all current ID numbers (license, DEA, Medicare/Medicaid and NPI numbers)
4. Additional education/training completed, since last credentialing approval.
5. Current Hospital/Practice/Teaching Appointments or Affiliations – include Credentialing Office/Program Director contact phone #, fax# and email. Make sure to list start date and end date, if applicable **(Month/Year).**
6. Health Status Attestation; **attach a separate explanation statement** for "yes" response(s)
7. Disclosure questions**; attach a separate explanation statement** for any "yes" response(s) for Q. 2-18. Use page 8 for "yes" response to Q.1.

Other Required Documentation:

1. Background Information Disclosure Form (BID). **Please use Department of Health Services, Division of Quality Assurance Form F-82064 (07/2018).** Please make sure Section B, question 6 is filled out with agency name. Agency(s) must submit recent background check results, meaning results must be within 90 days of application submission and be within 180 days of the recredentialing decision.
2. Primary office location clinic hours – Please make sure to fill out the bottom of the page with after hours coverage arrangements.
3. Attach copy of current **Professional Liability Certificate(s) of Insurance.**
4. Independent Contractor form (found on website) (Only if an independent contractor)

Additional Requirements for Advanced Practice Nurses

1. Documentation of physician collaboration arrangement
2. Copy of current **Specialty Certification** from the American Nurses Credentialing Center *(or equivalent national accreditor, as deemed acceptable by the BHD Provider Network)*

Failure to make timely reapplication or to submit a complete application may result in lapse in your approval to provide services to BHD Provider Network clients. Please email the completed Recredentialing Application and all required documentation, **not less than 90 days prior to current credentialing approval expiration**, to: BHDCredentialing@milwaukeecountywi.gov

If you have any questions regarding recredentialing, please refer to the **BHD Provider Network Credentialing Program** located in ***PolicyStat*** or contact MCBHD at the above email, and a representative from the Provider Network will be in contact with you.

Sincerely,

The Milwaukee County Behavioral health Division Provider Network – CARS & Wraparound Milwaukee

Milwaukee County Behavioral Health Division
PROVIDER NETWORK – RECREDENTIALING
9455 WATERTOWN PLANK ROAD, MILWAUKEE, WI 53226

Application for Network Participation to: ☐**Community Access to Recovery Services** ☐**Wraparound Milwaukee**

INSTRUCTIONS: **Applicant must fill out the application in its entirety and provide all required supporting documentation in accordance with the instructions given in the application cover letter**. 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 all practice sites, identify a primary, mailing and billing address.

Office #1

Office Name Office Street Address		Check all applicable boxes: ☐ Primary Office ☐ Secondary Office ☐ Mailing Address ☐ Billing 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 Office Street Address		Check all applicable boxes: ☐ Primary Office ☐ Secondary Office ☐ Mailing Address ☐ Billing 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 Office Street Address		Check all applicable boxes: ☐ Primary Office ☐ Secondary Office ☐ Mailing Address ☐ Billing 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	*Primary*	*Secondary*	*Board Certified (Yes or No)*		*Name of Board (if applicable)* *(i.e., ABPN, AOA, ANCC, ASPPB)*	*Year Certified*	*Last Re-Certified*	*Expiration Date*
	☐	☐	☐	☐				
	☐	☐	☐	☐				
	☐	☐	☐	☐				
	☐	☐	☐	☐				

ID NUMBERS

State License: ***List all CURRENT professional licenses.***

Type of Wisconsin License	*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		
Medicaid Provider Number		
National Provider Identifier Number		**N/A**

SERVICES: List All Services You Are Requesting To Provide *(ALL APPLICANTS)*

Service Code	*Service Name (Attach Separate List if Additional and Check Box – See Attached ☐)*

HOSPITAL & AMBULATORY SURGERY CENTER 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. Enter additional affiliations on a separate sheet of paper and attach to the application, if more than seven (7).* ***Report practice affiliations on page 5.***

Do not include Residency or Internship information in this area.

☐ **Check box if NONE**

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

PRACTICE AFFILIATION: ***List all current practice affiliations or any held within the past three (3) years.***
(Report hospital affiliations on page 3) ***(REQUIRED FOR ALL APPLICANTS)***

☐ **Check box if NONE**

Name of Institution		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	
Name of Institution		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	
Name of Institution		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	
Name of Institution		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	
Name of Institution		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	
Name of Institution		**Job Title**	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Supervisor E-Mail Address	Supervisor's Name	

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

Current Liability Carrier ☐ **Individual/Personal Coverage or** ☐ **Employer Coverage**

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 or** ☐ **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 or** ☐ **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

DISCLOSURE QUESTIONS - If you answer "YES" to questions numbered 2 through 18, please provide details on a SEPARATE PAGE AND ATTACH. 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

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 documents 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 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.

Please Print

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

Your Relationship to Patient (Attending Practitioner, Surgeon, Assistant Surgeon, Consultant, etc.)

Allegation

Liability Carrier when Incident Occurred

Additional Named Defendant(s)
☐ Yes ☐ No

Claim Status

☐ ***OPEN*** *– If open, amount 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.

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 BHD Provider Network Credentialing Committee, 11-21-2019; Service Code Section added 11-23-2019

Rev. 11-2019

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 DIVISION (BHD) PROVIDER NETWORK-CARS &/OR WRAPAROUND***, 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 BHD, its 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 BHD and to consult with BHD 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 the Milwaukee County Behavioral Health Division, its Provider Network and/or their representatives to conduct 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, BHD and all representatives of BHD and the Provider Network for their acts performed and statements made in connection with evaluating my application and my 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 BHD or its Provider Network, concerning my professional competence, ethics, character or other qualifications for credentialing and network participation, and I hereby consent to the release of such information to BHD.

Burden of Providing Accurate and Complete Information

I understand and agree that I, as an applicant for credentialing and 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 BHD. 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 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 Provider Network Credentialing Program and Policies

In making this application for credentialing and network participation, I acknowledge that I have received, or been given access to, and read the Provider Network Credentialing Program and provider network policies and procedures. I agree to be bound by the terms of the Credentialing Program and provider network 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 in the provider network. I further specifically acknowledge and accept the provisions of said Provider Network Credentialing Program relating to confidentiality, credentialing and the continuation of network participation, if approved.

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

I agree that the practitioner credentialing/recredentialing appeals process set forth in the BHD Provider Network Credentialing Program 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 network affiliation, if approved. I also agree to provide additional information, as requested. If approved, I agree to keep the BHD Provider Network 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 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 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: ____

BHD and its Provider Network will treat this application and any information secured in connection therewith in confidence, to the best of its ability, in accordance with the BHD 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. 5/2019

Milwaukee County Behavioral Health Division
PROVIDER NETWORK - RECREDENTIALING
9455 WATERTOWN PLANK ROAD, MILWAUKEE, WI 53226

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

Primary Office Location

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

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 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: ______________________________