Network Participation Request

Instructions

Thank you for your interest in network participation. Select the appropriate box(es) you are requesting for participation:

WEA Trust ☐
Health Tradition ☐

Please read the following before completing this form**:**

- **If your organization is already contracted for network participation, you do not need to complete a Network Participation Request form.**
- **Completion of this Request does not guarantee your network participation**. However, if you receive an invitation to join our network, completion of this form will ensure that the correct agreement is sent for your review and signature.
- **We are unable to offer a contract for network participation if your specialty is one of the following**:

  WEA Trust -
    - Routine vision: Contact National Vision Administrators (NVA) at (888) 682-2020 or providers@e-nva.com.
    - General dentistry: Contact Delta Dental of Wisconsin at (800) 836-0490 or PR@deltadentalwi.com.
    - Independent chiropractic: Contact Magellan Healthcare at (800) 432-3640 or www.hsminc.com.
    - Independent PT/ST/OT: Contact Magellan Healthcare at (800) 432-3640 or www.hsminc.com.

  Health Tradition –
    - General dentistry: Contact Delta Dental of Wisconsin at (800) 836-0490 or PR@deltadentalwi.com.
    - Independent chiropractic: Contact Magellan Healthcare at (800) 432-3640 or www.hsminc.com.
    - Independent PT/ST/OT: Contact Magellan Healthcare at (800) 432-3640 or www.hsminc.com.
- **Please return your completed Network Participation Request form and required documentation as indicated by the instructions at the end of this form.**
- **Your participation request will be reviewed by the Network Access and Composition Committee. A response will generally be provided within 60 days of receipt of your request.**

Section 1: Organization/Practice & Contact Information

Legal Business Name *(as it appears on W-9)*:	
Federal Tax ID Number:	Organization (Type 2) NPI Number:

Form Submitted by (name/title):		
Street Address:		
City:	State:	Zip Code:
Phone Number (with Area Code):	Fax Number (with Area Code):	
E-mail: Website Address:	Date Submitted:	

Billing Entity (if other than Legal Business Name):		
Remittance Address:		
City:	State:	Zip Code:
Phone Number (with Area Code):	Fax Number (with Area Code):	
E-mail:		

Section 2: General Information

1. Please provide a summary of your practice specialty and/or services that you wish to offer members:

2. Are you an employee or an affiliate of a large provider system or an independent physician association (IPA)?

☐ Yes ☐ No

If 'Yes', please list all that apply:

3. Please list your hospital affiliations, if applicable:

Hospital Name:	Federal Tax ID Number:
Hospital Name:	Federal Tax ID Number:
Hospital Name:	Federal Tax ID Number:
Hospital Name:	Federal Tax ID Number:

4. Are you leaving an existing practice which is currently contracted? ☐ Yes ☐ No

If 'Yes', please supply the following:

Group/Individual Practice Name:	
Federal Tax ID Number:	Organization (Type 2) NPI Number:

5. **Facilities only (i.e., hospitals, ambulatory surgical centers, skilled nursing facilities):** Do you employ any practitioners and bill for their services?

☐ Yes ☐ No *If 'Yes', please list all practitioners in Section 4.*

6. **Behavioral Health only:**

Ages of patients treated:	
How long does a NEW patient wait for an appointment?	
How long does an ESTABLISHED patient wait for an appointment?	
How long does an ESTABLISHED patient with an URGENT NEED wait for an appointment?	
How are after-hour emergencies managed?	

Section 3: Service Location Information

Please provide the following information for each of your service location(s). Copy this page as needed to list all locations, or provide your own listing that includes all information required below.

Location # 1

Location or Clinic Name:		
Address:		
City:	State:	Zip Code:
Phone Number for Appointments (with Area Code):	Fax Number (with Area Code):	
E-mail:		

Location # 2

Location or Clinic Name:		
Address:		
City:	State:	Zip Code:
Phone Number for Appointments (with Area Code):	Fax Number (with Area Code):	
E-mail:		

Location # 3

Location or Clinic Name:		
Address:		
City:	State:	Zip Code:
Phone Number for Appointments (with Area Code):	Fax Number (with Area Code):	
E-mail:		

Location # 4

Location or Clinic Name:

Address:

City: State: Zip Code:

Phone Number for Appointments (with Area Code): Fax Number (with Area Code):

E-mail:

Section 4: Practitioner Information

Please provide the following information for all practitioners billing under this tax ID. Copy this page as needed to list all practitioners or provide your own listing that includes all information required below.

First Name	MI	Last Name	Credential(s)	Specialty	Individual NPI	Gender	CAQH ID#	Service Locations (Per Section 3)
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Form Submission Instructions:

Important: The following elements are required with the submission of your application. If these items are not included, your application will be considered incomplete:

- **W-9 Form**. We require this information to ensure that we have accurate IRS reporting information on file.
- **A listing of your 10 most** frequently billed codes with fees. This applies to individual practitioner or clinics requesting participation.

Questions and completed forms can be sent via e-mail to: providernetworkrequests@weatrust.com or providernetworkrequests@healthtradition.com

NOTE: This is not a credentialing application or a provider agreement. It is used for assessment purposes only.