Arise HEALTH PLAN
WPS Health Plan, Inc.

Facility Data Sheet

WPS HEALTH INSURANCE

Use this form to notify Arise Health Plan and WPS Health Insurance of any changes, additions, or terminations to facilities within your organization. ***Questions? Call 920-617-6325***

Please return form to:

ATTN: Network Development Department FAX: (920) 490-6923
Email: GBNetworkDevelopmentDept@AriseHealthPlan.com

Complete sections 1, 2, and 3. Check appropriate action and complete accompanying section.

1. Contact Information			**Today's Date**	
Name				
Organization				
Address				
City, State, Zip				
Telephone Number		Fax Number		
Federal Tax ID#		Email Address		

2. Credentialing Contact	☐ Check if same as contact info above		
Name			
Organization			
Address			
City, State, Zip			
Telephone Number		Fax Number	
Email address			

3. Facility information			
Location Name			
Facility NPI		CCN #	

	ADD FACILITY	Please complete Section A
	TERM FACILITY	Please complete Section B
	UPDATE FACILITY	Please complete section C

SECTION A – ADD FACILITY (Include copy of W-9)

Location Street Address			
City, State, Zip			
County			
Telephone Number		Fax Number	
Medicare #		Medicaid #	
Effective Date			

SECTION A – ADD FACILITY (continued)

Billing information			
Name on 1099 Tax Form			
Federal Tax ID			
Remit to Name			
Address			
City, State, Zip			
Telephone Number		Fax Number	

Please indicate your facility type/services by checking the appropriate box(es):

	Ambulatory Surgery Center		Laboratory*
	Arrhythmia Monitoring/Cardiac Monitoring		Mammography
	Audiology		Magnetic Resonance Imaging
	Behavioral Health Facility		Occupational Therapy
	Breast Prosthetics		Pain Management
	Clinic		Physical Therapy
	Dialysis		Prosthetics/Orthotics
	Drug and Alcohol Facility – Outpatient		Radiology Services*
	Drug and Alcohol Services – Inpatient		Rehabilitation Facility
	Durable Medical Equipment		Skilled Nursing Facility
	EEG & Sleep Studies		Speech Therapy
	Home Health Care		Transitional Rehabilitation Unit
	Home Infusion		Urgent Care Facility
	Hospice		Wound Vac Therapy

	Hospital	# Beds:	
	Cardiac Catheterization Services		Mammography
	Cardiac Surgery Program		Occupational Therapy
	CCU/ICU		Outpatient Dialysis
	Diagnostic Radiology		Outpatient Infusion/Chemotherapy
	Hospital Based Urgent Care		Physical Therapy
	Inpatient Psychiatric Services		Speech Therapy

**Will not appear in directory listings*

SECTION B –TERM FACILITY

Facility Information	Location to Term
Facility Name	
Address	
City, State, Zip	
Termination Date	

SECTION C – UPDATE FACILITY (Include copy of updated W-9)

Facility Information	Location was:	Change to:	Eff. Date
Facility Name			
Address			
City, State, Zip			
Telephone Number			
Fax Number			

For internal use only

Network Management	Arise ☐	WPS ☐	Date Sent to Cred Dept		Initials	
Credentialing			Date Application Sent		Initials	