

# Wellmark, Inc.

## Universal Facility & Entity Application Addendum

To apply for participation in Wellmark networks, please complete this Addendum in combination with the Iowa Statewide Universal Facility Application. Mark N/A for the questions that are not applicable to your facility type. For specific contracting and credentialing requirements, review the Contracts and Credentialing section of the Wellmark Provider Guide, on the Provider section of Wellmark.com.

### ADDITIONAL DOCUMENTATION TO INCLUDE:

- CMS Approval Letter: hospital, hospice, skilled nursing facility, dialysis center, home health agency, ambulatory surgery center, freestanding substance abuse facility, rural health clinic, federally qualified health center, home infusion therapy
- CMS Survey document and cover letter if not nationally accredited: ambulatory surgery center, freestanding substance abuse facility/chemical dependency treatment facility, home health agency, hospice, hospital/specialty hospital, skilled nursing facility

### SECTION M. GENERAL INFORMATION

Scheduling Phone Number \_\_\_\_\_ TDD Phone Number (hearing impaired) \_\_\_\_\_

Administrator's Name \_\_\_\_\_ Administrator's email address \_\_\_\_\_

Credentialing Contact Name \_\_\_\_\_ Credentialing email address \_\_\_\_\_

Credentialing Address \_\_\_\_\_

Credentialing City, State, Zip \_\_\_\_\_

Credentialing Phone number \_\_\_\_\_

What languages are spoken at this address? \_\_\_\_\_

Do you bill electronically to Wellmark for facility services?  Yes  No

Do you bill electronically to Wellmark for professional services?  Yes  No

Do you store electronic medical records?  Yes  No

Does your location have public transportation access?  Yes  No

Do you have the ability to submit claims to CMS?  Yes  No

Does your organization own or have ownership interest in a healthcare facility or organization with which you are affiliated? (independent lab, nursing home, retail pharmacy, freestanding radiology/imaging center, rehab, freestanding sleep center, durable medical equipment supplier)?  Yes  No

If yes, please provide name of facility, address, percent of ownership, owned by, name of organization. \_\_\_\_\_

In what networks does your facility or entity wish to participate?  Classic Blue  Alliance Select  Select First

TRICARE  Blue Access  Blue Choice  Blue Advantage  Medicare Advantage

### Radiology Center Services/Capacity

Please check the services that are available at your hospital/facility. These may or may not be a covered benefit.

<input type="checkbox"/> Bone Scan	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> CT Scan	<input type="checkbox"/> PET Scan
<input type="checkbox"/> DEXA Scan	<input type="checkbox"/> PET/CT
<input type="checkbox"/> Echocardiography	<input type="checkbox"/> PET/CTA
<input type="checkbox"/> Mammography	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> MRA	<input type="checkbox"/> Ultra Sound
<input type="checkbox"/> MRI	

### SECTION N. EFFECTIVE DATE

What is the effective date to perform services for Wellmark members? \_\_\_\_\_

**SECTION O. PROVIDER IDENTIFICATION NUMBERS**

Do you currently have a state certification number?  Yes  No If yes, please list: \_\_\_\_\_  
Enter your National Provider Identifier (NPI) number.

Acute hospital \_\_\_\_\_ Home Health Agency \_\_\_\_\_ Rehab \_\_\_\_\_  
Ambulance \_\_\_\_\_ Home Infusion Therapy \_\_\_\_\_ Rural Health Clinic \_\_\_\_\_  
Ambulatory Surgery Center \_\_\_\_\_ Hospice \_\_\_\_\_ Skilled Nursing \_\_\_\_\_  
CMHC \_\_\_\_\_ Independent Lab \_\_\_\_\_ Sleep Center \_\_\_\_\_  
Dialysis \_\_\_\_\_ Orthotic/Prosthetic \_\_\_\_\_ Swing-bed \_\_\_\_\_  
DME \_\_\_\_\_ PMIC \_\_\_\_\_ Visiting Nurse Association \_\_\_\_\_  
FQHC \_\_\_\_\_ Psychiatric \_\_\_\_\_ Other: \_\_\_\_\_  
Freestanding Radiology \_\_\_\_\_ Public Health Agency \_\_\_\_\_

If you have multiple facilities, please list each name in Section EE.

**SECTION P. PROFESSIONAL LIABILITY INSURANCE**

Wellmark needs liability information to cover your effective date and also when you are credentialed by Wellmark. If the liability information in Section E of this application doesn't cover both of those dates, please provide additional coverage information.

Carrier Name \_\_\_\_\_ City / State \_\_\_\_\_  
Policy Number \_\_\_\_\_  
\$ Amounts Per Occurrence \_\_\_\_\_ \$ Amounts Aggregate \_\_\_\_\_  
Date from (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_ Date to (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION Q. AMBULANCE SERVICE**

Does your ambulance service operate on donations?  Yes  No  
Does your ambulance service charge a flat fee for services?  Yes  No  
Is your ambulance service hospital based?  Yes  No

If yes, please provide the name of the hospital and location.

Name of hospital: \_\_\_\_\_  
City, State: \_\_\_\_\_

**SECTION R. DURABLE MEDICAL EQUIPMENT SUPPLIER**

- Please provide accreditation information in Section E of this application.
- If you provide orthotics and prosthetics, see Section W below.

If you do not have the ability to bill CMS, please explain: \_\_\_\_\_

**SECTION R. DURABLE MEDICAL EQUIPMENT SUPPLIER (cont.)**

**Check supplies provided**

<input type="checkbox"/> Air Mattress (tech)	<input type="checkbox"/> Augmentative Device (tech)	<input type="checkbox"/> Back-Up Equipment (tech)
<input type="checkbox"/> Bath Chair (med supp)	<input type="checkbox"/> Bi-Pap (resp) (tech)	<input type="checkbox"/> Breast Pumps (med subb)
<input type="checkbox"/> Chest Compression Apparatus for Cystic Fibrosis (resp)	<input type="checkbox"/> CPM Machine (tech)	<input type="checkbox"/> Commodes (med supp)
<input type="checkbox"/> Computer Software (tech)	<input type="checkbox"/> Diabetic Shoes/Inserts (tech)	<input type="checkbox"/> Diabetic Supplies (med supp)
<input type="checkbox"/> Easy Stander (tech)	<input type="checkbox"/> Emergency Maintenance (tech)	<input type="checkbox"/> Enteral (med supp)
<input type="checkbox"/> EZ Lock Wheelchair (mobile)	<input type="checkbox"/> Feeding Pumps (tech)	<input type="checkbox"/> Grab Bars (tech)
<input type="checkbox"/> Hand Control for Vehicle (mobile)	<input type="checkbox"/> Hearing Aids (other)	<input type="checkbox"/> Home Care (other)
<input type="checkbox"/> Hospital Beds (tech)	<input type="checkbox"/> Infusion Pumps (tech)	<input type="checkbox"/> Infusion Therapy - Adult (med supp)
<input type="checkbox"/> Infusion Therapy Pediatric (med supp)	<input type="checkbox"/> Jazzy Wheelchair (mobile)	<input type="checkbox"/> Mechanical Ventilators (resp)
<input type="checkbox"/> Medical Equipment Repairs/Service (tech)	<input type="checkbox"/> Medical Supplies (med supp)	<input type="checkbox"/> Ostomy supplies (med supp)
<input type="checkbox"/> Parenteral (med supp)	<input type="checkbox"/> Pediatric Vents (resp)	<input type="checkbox"/> Pulse Oximeter (tech)
<input type="checkbox"/> Respiratory (resp)	<input type="checkbox"/> Respite Care (other)	<input type="checkbox"/> Restrain System (med supp)
<input type="checkbox"/> RT-300 Ergometer Cycle (tech)	<input type="checkbox"/> Specialized Beds (tech)	<input type="checkbox"/> TPN (med supp)
<input type="checkbox"/> Urinary supplies	<input type="checkbox"/> Van Lift (mobile)	<input type="checkbox"/> Walker (med supp)
<input type="checkbox"/> Special Wheelchair - custom (mobile)	<input type="checkbox"/> Special Wheelchair - Manual (mobile)	<input type="checkbox"/> Wheelchair Lift Car (mobile)
<input type="checkbox"/> Wound Care supplies		

**SECTION S. FREESTANDING SUBSTANCE ABUSE CENTERS/CHEMICAL DEPENDENCY TREATMENT FACILITIES**

- Please provide a copy of the complete State Inspection Report
- Please provide accreditation information in Section E of the application
- TRICARE requires certification by KePro (www.kepro.com)

Is your facility equipped to provide acute inpatient management 24 hours a day?  Yes  No

How many beds do you have available for acute treatment? \_\_\_\_\_

**SECTION T. HOSPITAL/SPECIALIZED HOSPITAL**

- Please provide accreditation/certification information in Section E of the application.
- TRICARE requires freestanding mental health institutions and partial hospitalization programs to be certified by KePro (www.kepro.com)

Trauma Level:  Level 1  Level 2  Level 3  Level 4  Level 5  Not applicable

Do you participate with the National Disaster Medical Services (NDMS)?  Yes  No

**Check services provided**

<input type="checkbox"/> Acute Care	<input type="checkbox"/> Alcohol/Chemical Dependency - Adolescent Detox	<input type="checkbox"/> Alcohol/Chemical Dependency - Adolescent OP
<input type="checkbox"/> Alcohol/Chemical Dependency - Adolescent Partial Hospitalization	<input type="checkbox"/> Alcohol/Chemical Dependency - Adolescent Rehabilitation	<input type="checkbox"/> Alcohol/Chemical Dependency - Adult Detox
<input type="checkbox"/> Alcohol/Chemical Dependency - Adult OP	<input type="checkbox"/> Alcohol/Chemical Dependency - Adult Partial Hospitalization	<input type="checkbox"/> Alcohol/Chemical Dependency - Adult Rehabilitation
<input type="checkbox"/> Ambulance - Air	<input type="checkbox"/> Ambulance - Hospital-based	<input type="checkbox"/> Audiology

**SECTION T. HOSPITAL/SPECIALIZED HOSPITAL (cont.)**

**Check services provided**

<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Birthing Rooms	<input type="checkbox"/> Blood Bank
<input type="checkbox"/> Burn Unit	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiac
<input type="checkbox"/> Cardiac Rehabilitation	<input type="checkbox"/> Cochlear Implant Surgery	<input type="checkbox"/> CT Scan
<input type="checkbox"/> Diabetes Education	<input type="checkbox"/> Dialysis - OP	<input type="checkbox"/> EEG monitoring
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Gamma Knife	<input type="checkbox"/> Geriatric Services
<input type="checkbox"/> Home Health Services (not separately Medicare certified)	<input type="checkbox"/> Home Infusion Therapy (not separately Medicare Certified)	<input type="checkbox"/> Hospice Care
<input type="checkbox"/> Hyperbaric Treatment	<input type="checkbox"/> ICU-Intensive Care Unit	<input type="checkbox"/> IOP - Intensive Otpt Program
<input type="checkbox"/> Lab - OP	<input type="checkbox"/> Lab Services	<input type="checkbox"/> Lithotripsy
<input type="checkbox"/> Mammography	<input type="checkbox"/> Maternity	<input type="checkbox"/> MRA
<input type="checkbox"/> MRI	<input type="checkbox"/> Neonatal ICU Level 1	<input type="checkbox"/> Neonatal ICU Level 2
<input type="checkbox"/> Neonatal ICU Level 3	<input type="checkbox"/> Neurology Services	<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Nursery	<input type="checkbox"/> Obstetrics	<input type="checkbox"/> Occupational Therapy - IP
<input type="checkbox"/> Occupational Therapy - OP	<input type="checkbox"/> Occupational Therapy - IP/OP	<input type="checkbox"/> Oncology
<input type="checkbox"/> Open Heart Surgery	<input type="checkbox"/> Orthopedic Services	<input type="checkbox"/> Outpatient Surgery
<input type="checkbox"/> Pain Management	<input type="checkbox"/> Partial Hospitalization	<input type="checkbox"/> Pediatric Hematology/Oncology
<input type="checkbox"/> Pediatric ICU	<input type="checkbox"/> Pediatric Emergency Care	<input type="checkbox"/> Pediatric Physical Therapy
<input type="checkbox"/> Pediatric Rehabilitation	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> PET Scan
<input type="checkbox"/> Physical Therapy - IP	<input type="checkbox"/> Physical Therapy - OP	<input type="checkbox"/> Physical Therapy - IP/OP
<input type="checkbox"/> Psychiatric Services - Adolescent Eating Disorder	<input type="checkbox"/> Psychiatric Services - Adolescent IP	<input type="checkbox"/> Psychiatric Services Adolescent Outpatient
<input type="checkbox"/> Psychiatric Services - Adolescent Partial Hospitalization	<input type="checkbox"/> Psychiatric Services - Adult Eating Disorder	<input type="checkbox"/> Psychiatric Services - Adult IP
<input type="checkbox"/> Psychiatric Services - Adult OP	<input type="checkbox"/> Psychiatric Services - Adult Partial Hospitalization	<input type="checkbox"/> Psychiatric Services Child IP
<input type="checkbox"/> Psych Unit (not separately Medicare certified)	<input type="checkbox"/> Radiation Center	<input type="checkbox"/> Radiation Oncology
<input type="checkbox"/> Rehab Unit (not separately Medicare certified)	<input type="checkbox"/> Residential Care	<input type="checkbox"/> Sleep Studies
<input type="checkbox"/> SNF Unit (not separately Medicare certified)	<input type="checkbox"/> Speech Therapy - IP	<input type="checkbox"/> Speech Therapy - OP
<input type="checkbox"/> Speech Therapy IP/OP	<input type="checkbox"/> Sports Medicine	<input type="checkbox"/> Swing Bed (not separately Medicare certified)
<input type="checkbox"/> Transplant - Bone Marrow	<input type="checkbox"/> Transplant - Cornea	<input type="checkbox"/> Transplant - Heart
<input type="checkbox"/> Transplant - Heart/Lung	<input type="checkbox"/> Transplant - Kidney	<input type="checkbox"/> Transplant - Liver
<input type="checkbox"/> Transplant - Liver/Kidney	<input type="checkbox"/> Transplant - Pancreas/Kidney	<input type="checkbox"/> Transplant - Small Intestine
<input type="checkbox"/> Transplant - Small Intestine/Liver	<input type="checkbox"/> Transplant - Tissue	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Ultra Sound	<input type="checkbox"/> Urgent Care	<input type="checkbox"/> Ventilator Care

**SECTION U. INDEPENDENT LABORATORY**

What level of CLIA certification does the lab have?  Accreditation  Waiver  Compliance  Registration  
 Provider-Performed Microscopy Procedures

Name of the facility on the CLIA certificate \_\_\_\_\_

**SECTION V. ORTHOTICS/PROSTHETICS**

- Please provide Accreditation information in Section E of this application.
- If you only provide mastectomy fitting, you must have an ABC or BOC certified fitter on staff. Please provide the fitter's name and certification information including certification dates.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Name Certification Certification Date (mm/dd/yyyy)

What services do you provide (mark all that apply)?  Orthotics  Prosthetics  Mastectomy  Ocularist

**Check services/supplies provided**

<input type="checkbox"/> Back-Up Equipment	<input type="checkbox"/> Custom Fabricated Orthotics	<input type="checkbox"/> Custom Fit Orthotics
<input type="checkbox"/> Diabetic Shoes/Inserts	<input type="checkbox"/> Emergency Maintenance	<input type="checkbox"/> Limb Prosthetics
<input type="checkbox"/> Medical Equipment Repairs/Service	<input type="checkbox"/> Off the Shelf Orthotics	<input type="checkbox"/> Orbital Prosthesis
<input type="checkbox"/> Orthotics	<input type="checkbox"/> Prosthetics	<input type="checkbox"/> Prosthetic Devices
<input type="checkbox"/> Respiratory		

**SECTION W. PUBLIC HEALTH AGENCY/VISITING NURSE ASSOCIATION**

- Public Health Agency: Please provide documentation from the Board of Supervisors or Board of Health designating your agency as the public health agency for your county/area
- Visiting Nurse Association: Please provide documentation from CMS indicating your ability to bill for immunizations given to Medicare beneficiaries

As a Public Health Agency, which counties have you been designated as the public health agency? \_\_\_\_\_

As a Visiting Nurse Association, are you a member of the Visiting Nurse Association of America?  Yes  No

As a Visiting Nurse Association, are you certified by CMS to bill immunization?  Yes  No

**SECTION X. PSYCHIATRIC MEDICAL INSTITUTIONS for CHILDREN**

- Please provide accreditation information in Section E of this application

How many beds do you have available for treatment? \_\_\_\_\_

How many hours per day of onsite nursing are available?  Less than 8 hours  8 or more hours

Is a RN available 24 hours a day, 7 days a week?  Yes  No

Do you have one or more fulltime staff psychiatrists?  Yes  No

If yes, please provide the name and state license information below.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Name License Number State Effective Date (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Name License Number State Effective Date (mm/dd/yyyy)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Name License Number State Effective Date (mm/dd/yyyy)

## SECTION Y. RADIOLOGY/IMAGING CENTER

- Please provide accreditation information in Section E of this application

Type of Services	Check if Service is Offered	Accredited By (Organization Name(s))	Date Accredited	Accreditation Renewal Date
CT			/ /	/ /
CTA			/ /	/ /
Nuclear Cardiology			/ /	/ /
PET			/ /	/ /
PET/CT			/ /	/ /
Mammography			/ /	/ /
MRI			/ /	/ /
MRA			/ /	/ /
Echocardiography			/ /	/ /
Other (specify)			/ /	/ /
Other (specify)			/ /	/ /
Other (specify)			/ /	/ /
Other (specify)			/ /	/ /

### Imaging Equipment Used at this Site

Please list each piece of equipment used to provide services. Indicate Type of Service in the "Type" column - CT, CTA, Nuclear Cardiology, PET, PET/CT, MRI, MRA, Echocardiography, Other (specify). Complete all information related to that piece of equipment.

Type	Manufacturer	Model	Year

## SECTION Z. RURAL HEALTH CLINICS / FEDERALLY QUALIFIED HEALTH CENTERS

- Rural Health Clinics: Please provide a copy of the Interim Rate Letter.

Facility Type:  RHC  FQHC – rural  FQHC - urban

List the **Iowa** counties where you provide services. \_\_\_\_\_

List the **South Dakota** counties where you provide services. \_\_\_\_\_

Provide the requested information regarding all of the physicians and/or practitioners at your clinic in the table below.

**SECTION Z. RURAL HEALTH CLINICS / FEDERALLY QUALIFIED HEALTH CENTERS (cont.)**

Physician/Practitioner Name, degree/title <i>(List every physician or practitioner providing care at the RHC or FQHC)</i>	NPI <i>(if applicable)</i>	Will this physician or practitioner bill for services outside of the encounter rate?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION AA. SLEEP CENTERS – FREESTANDING OR HOSPITAL-BASED**

- To be listed in the provider directory, your sleep center must be contracted and credentialed.
- Please provide accreditation information in Section E of this application.

How many beds do you have available for sleep studies? \_\_\_\_\_

Do you have a medical director or staff physician who is Board Certified in Sleep Medicine?  Yes  No

If yes, please provide the name(s) below.

_____	_____	_____/_____/_____
Name	Board	Expiration Date (mm/dd/yyyy)
_____	_____	_____/_____/_____
Name	Board	Expiration Date (mm/dd/yyyy)
_____	_____	_____/_____/_____
Name	Board	Expiration Date (mm/dd/yyyy)

Is your medical director or staff physician available to provide face-to-face review of study results to sleep center patients?

Yes  No

**SECTION BB. SKILLED NURSING FACILITY**

- Please provide accreditation, certification and licensure information in Section E of this application.

**Mark services provided**

<input type="checkbox"/> Behavioral Health Dual Diagnosis	<input type="checkbox"/> Cardiac Drips	<input type="checkbox"/> Cardiac Rehabilitation
<input type="checkbox"/> Hemo Dialysis	<input type="checkbox"/> Hyperbaric Treatment	<input type="checkbox"/> Inpatient
<input type="checkbox"/> IV Administration	<input type="checkbox"/> Levels of Care	<input type="checkbox"/> Neurology Services
<input type="checkbox"/> Occupational Therapy - IP	<input type="checkbox"/> Occupational Therapy - IP/OP	<input type="checkbox"/> Occupational Therapy - OP
<input type="checkbox"/> Orthopedic Services	<input type="checkbox"/> Ostomy Care	<input type="checkbox"/> Oxygen Therapy
<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Pediatric Vents	<input type="checkbox"/> Post Hospitalization
<input type="checkbox"/> Post Transplant	<input type="checkbox"/> Physical Therapy - IP	<input type="checkbox"/> Physical Therapy - IP/OP
<input type="checkbox"/> Physical Therapy - OP	<input type="checkbox"/> Residential Care	<input type="checkbox"/> Specialized/Complex Wound Care
<input type="checkbox"/> Specialty Beds (types)	<input type="checkbox"/> Speech Therapy - IP	<input type="checkbox"/> Speech Therapy IP/OP
<input type="checkbox"/> Speech Therapy - OP	<input type="checkbox"/> Suction Therapy	<input type="checkbox"/> Trachs
<input type="checkbox"/> Transportation	<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Vents
<input type="checkbox"/> Wound Care	<input type="checkbox"/> Wound Vac	

## SECTION CC. HOME INFUSION THERAPY PROVIDERS

- Please provide accreditation information in Section E of this application.

What type of pharmacy license do you hold?  General  Hospital  Non-Resident

Yes  No Does this location meet the State sterile compounding requirements?

Yes  No Is this location recognized by CMS as a DME supplier and a pharmacy?

Yes  No Does the Medical Director have expertise in infusion therapy services to provide overall direction for the clinical aspect of the home infusion therapy?

Yes  No Does this location have a medical director or RN that develops, coordinates and supervises all activities of nursing services, including responsibility for assuring that only qualified individuals administer home infusion drugs?

Yes  No Are RNs providing direct patient care?

Yes  No Do you subcontract for the nursing services?

If yes, please provide the name of the agency used for subcontracted services: \_\_\_\_\_

Yes  No Do you deliver infusion services within 24 hours of receipt of physician's order?

Yes  No Do you have a system ensuring prompt delivery and appropriate storage of pharmaceuticals, supplies and maintenance and service of equipment?

Yes  No Do you provide a medical waste disposal system for in-home use?

Yes  No Do you have a documented recall policy and procedure in the event of an FDA recall on an infusion product?

Yes  No Do you provide care under general supervision of patient's physician?

Yes  No Is the plan of care reviewed at least every 30 days or as often as the patient's physician deems necessary?

**SECTION DD. CORPORATE CONTRACTS LIST OF LOCATIONS - To be used by Corporate Providers**

List of locations – include any locations in Iowa, South Dakota or counties bordering either state  
Please complete the information below for each location or if you have a spreadsheet that would include all of this information, please attach it to this application. If additional space is needed, please copy this page. Wellmark will determine eligibility for networks according to our requirements and each specific location.

- Check if the APPLICATION CONTACT (Section B) is the same for all your locations. If not, please provide this information per location in Section FF.
- Check if the BILLING INFORMATION (Section C) is the same for all your locations. If not, please provide this information per location in Section FF.
- Check here if the MEDICAL DIRECTOR (Section D) is the same for all your locations. If not, please provide this information per location in Section FF.
- Check here if the ACCREDITATION/CERTIFICATION/LICENSURE INFORMATION (Section E) applies to all your locations. If not, please provide this information per location in Section FF.
- Check here if the LIABILITY INFORMATION (Sections F & Q) applies to all your locations. If not, please provide this information per location in Section FF.

NPI: \_\_\_\_\_ TIN (if different at this site): \_\_\_\_\_  
State Certification Number: \_\_\_\_\_ Which state(s)? \_\_\_\_\_  
Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Scheduling Phone Number: \_\_\_\_\_ TDD Phone number (hearing impaired): \_\_\_\_\_  
Effective Date to See Wellmark members: \_\_\_\_\_  
Languages spoken at site: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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NPI: \_\_\_\_\_ TIN (if different at this site): \_\_\_\_\_  
State Certification Number: \_\_\_\_\_ Which state(s)? \_\_\_\_\_  
Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Scheduling Phone Number: \_\_\_\_\_ TDD Phone number (hearing impaired): \_\_\_\_\_  
Effective Date to See Wellmark members: \_\_\_\_\_  
Languages spoken at site: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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NPI: \_\_\_\_\_ TIN (if different at this site): \_\_\_\_\_  
State Certification Number: \_\_\_\_\_ Which state(s)? \_\_\_\_\_  
Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Scheduling Phone Number: \_\_\_\_\_ TDD Phone number (hearing impaired): \_\_\_\_\_  
Effective Date to See Wellmark members: \_\_\_\_\_  
Languages spoken at site: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION DD. CORPORATE CONTRACTS LIST OF LOCATIONS - To be used by Corporate Providers (cont.)**

NPI: \_\_\_\_\_ TIN (if different at this site): \_\_\_\_\_  
State Certification Number: \_\_\_\_\_ Which state(s)? \_\_\_\_\_  
Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Scheduling Phone Number: \_\_\_\_\_ TDD Phone number (hearing impaired): \_\_\_\_\_  
Effective Date to See Wellmark members: \_\_\_\_\_  
Languages spoken at site: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NPI: \_\_\_\_\_ TIN (if different at this site): \_\_\_\_\_  
State Certification Number: \_\_\_\_\_ Which state(s)? \_\_\_\_\_  
Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Scheduling Phone Number: \_\_\_\_\_ TDD Phone number (hearing impaired): \_\_\_\_\_  
Effective Date to See Wellmark members: \_\_\_\_\_  
Languages spoken at site: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NPI: \_\_\_\_\_ TIN (if different at this site): \_\_\_\_\_  
State Certification Number: \_\_\_\_\_ Which state(s)? \_\_\_\_\_  
Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Scheduling Phone Number: \_\_\_\_\_ TDD Phone number (hearing impaired): \_\_\_\_\_  
Effective Date to See Wellmark members: \_\_\_\_\_  
Languages spoken at site: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NPI: \_\_\_\_\_ TIN (if different at this site): \_\_\_\_\_  
State Certification Number: \_\_\_\_\_ Which state(s)? \_\_\_\_\_  
Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Scheduling Phone Number: \_\_\_\_\_ TDD Phone number (hearing impaired): \_\_\_\_\_  
Effective Date to See Wellmark members: \_\_\_\_\_  
Languages spoken at site: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION EE. CERTIFICATION AND RELEASE**

Applicants have the following rights:

- You may request to review the information submitted in support of your credentialing application.
- You may correct any erroneous information found in your credentialing file.
- You will be notified of any information collected during the credentialing process varies substantially from the information you submitted.

*For all Wellmark networks, you must sign and date this section. Please do not back date it. It will be returned if signature date is older than 60 days.*

**Confirmation of Provider Enrollment**

For an electronic summary of the provider’s network participation status resulting from this application, complete the following fields. If you would like others to receive this information, such as billing staff, include e-mail addresses on the lines provided.

Primary Contact \_\_\_\_\_

Primary Contact Phone Number \_\_\_\_\_

Primary Contact E-mail Address \_\_\_\_\_

Other E-mail Address(es) \_\_\_\_\_

**Note:** if a contract is being signed as part of the application process, this option is not available. Contract(s) and participation status will be sent by mail.

**Certification and Release**

I understand that any information entered on this application and any Wellmark, Inc. addenda appropriate to my specialty which subsequently is found to be false could result in immediate dismissal from any Wellmark program.

I hereby certify that the information contained in my completed Wellmark application is accurate, true and complete. I authorize release of information as may be required by Wellmark to process this application and understand and agree Wellmark may communicate with me through various means, including but not limited to telephone, mail, and /or email over the internet regarding this application. My signature on my complete application does not constitute a contract with Wellmark. By signing this application which represents all addenda by Wellmark, I authorize Wellmark to release this information to Wellmark subsidiaries and affiliates.

Authorized Signature \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

Authorized Person’s Name and Title (please type or print) \_\_\_\_\_

***Certification and Release*** of the individual preparing the application. Complete this section if this application has been prepared by someone other than the authorized person indicated above - include name and title

I, \_\_\_\_\_, hereby attest that the information included on this application is accurate, true, and complete and can be retrieved from the files located at

Facility Name \_\_\_\_\_ Street Address \_\_\_\_\_ City \_\_\_\_\_

Preparer’s Signature and Title \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

