DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services
F-01312 (12/2022)

IRIS PROVIDER APPLICATION

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. Applicants will not be considered as IRIS program service providers until all necessary paperwork is completed, submitted, and verified.

Agency Provider is defined as entities whose employees furnish the service or from which goods are purchased. Individual Provider is defined as a person who is in an independent practice and not employed by a provider agency.

Personally identifiable information on this form is collected to verify that the application is complete and accurate, and will be used only for this purpose.

PROVIDER DEMOGRAPHICS

Organization Name

Provider's Name (Last, First, MI)	Phone Number	Email Address ☐ *May be published in Provider Directory*

Title

Are you applying as (choose one): ☐ Agency Provider ☐ Individual Provider

Type of Application: ☐ Initial Application ☐ Reinstatement

W-9 Name (as shown on income tax return)	W-9 Business Name (if different from W-9 name)
W-9 Exempt: ☐ Yes ☐ No	State of Wisconsin Department of Financial Institutions ID Number:

BILLING AND CLAIMS CONTACT INFORMATION

Check all that apply: ☐ Primary Office ☐ Mailing Address ☐ Billing Address

National Provider Identifier (if applicable): NPI	Wisconsin Provider Management Identifier (if applicable): WPMI
Tax Identification Number: EIN/SSN	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name

Name – Contact Person	Phone Number	Email Address ☐ *May be published in Provider Directory*
Fax Number		Internet Address ☐ *May be published in Provider Directory*

Address	City	State	Zip Code	County

RENDERING PROVIDER CONTACT INFORMATION

Check all that apply: ☐ Primary Office ☐ Mailing Address ☐ Billing Address

National Provider Identifier (if applicable): NPI	Wisconsin Provider Management Identifier (if applicable): WPMI
Tax Identification Number: EIN/SSN	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name
Organization Name

Name – Contact Person	Phone Number Phone	Email Address ☐*May be published in Provider Directory* Email Address
Fax Number		Internet Address ☐*May be published in Provider Directory* Web Address

Address	City	State	Zip Code	County

DAILY OPERATIONS CONTACT INFORMATION

Check all that apply: ☐ Primary Office ☐ Mailing Address ☐ Billing Address

National Provider Identifier (if applicable): NPI	Wisconsin Provider Management Identifier (if applicable): WPMI
Tax Identification Number: EIN/SSN	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name

Name – Contact Person	Telephone Number	Email Address ☐ *May be published in Provider Directory*		
Fax Number		Internet Address ☐ *May be published in Provider Directory*		
Address	City	State	Zip Code	County

SERVICES TO BE PROVIDED: List the service(s) you wish to provide. Please reference the IRIS Service Definition Manual for a complete list of allowable services.

Services	**Does this service require a license or certification?**

LICENSING/CERTIFICATION: List all current licenses and certificates (if applicable). A copy of each is required with this application.

Title of Licensure/Certification	Type of Licensure/Certification	Licensure/Certification Number	State in which Licensure/Certification Obtained	Expiration Date

By signing below, I certify that background checks on all employees have been completed in accordance with the Wisconsin Caregiver Program.

If I am to provide specialized transportation, I certify that the vehicle used is and will be mechanically sound, has properly functioning lighting, safety, ventilation, and braking systems, and properly inflated tires without excessive wear. I further certify that proper licensing and insurance has been verified and is attached.

I understand and agree that this application will not be processed until it is deemed complete by DHS. It is my responsibility to provide a complete application. I understand and agree that the burden of producing adequate information in a timely manner and for resolving doubts is my responsibility.

I certify that the information in this document and all attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after provider approval has been awarded, may lead to suspension or termination of provider approval.

SIGNATURE – Provider	Date Signed

Please submit this application to your Fiscal Employer Agent (FEA) using ONE of the following methods:

AGENCY	FAX	EMAIL	GROUND MAIL
GT Independence	888-972-3891	customerservice@gtindependence.com	215 Broadus St. Sturgis, MI 49091
iLIFE	414-918-4463	IRIS.Vendor@iLIFE.org	2020 W Wells St Milwaukee, WI 53233
Outreach Health Services	877-901-5826	outreach.wi@outreachfiscalagent.com	204 3rd Avenue, Suite 110 P.O. Box 945 Osceola, WI 54020
Premier Financial Management Services	888-302-3607	vendorpaperwork@premier-fms.com	10425 W North Ave, Suite 345 Milwaukee, WI 53226

Information contained in email messages may be privileged and confidential. There is some risk that any information in an email you send may be disclosed to, or intercepted by, unauthorized third parties. By agreeing to allow the use of email as a method of communication to WI DHS, this indicates that you acknowledge and accept the possible risks associated with such communication.